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Day hospitals for geriatric patients

Scottish Hospital Centre
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CHAPTER 1 : INTRODUCTION

1.1 Although a number of papers have been written about day hospitals in recent years, little authoritative guide material about these has been published. However, it is clear that there is an increasing interest in this subject and that a number of day hospitals have been developed in purpose-built accommodation or in modified buildings. So far, no clear cut pattern of development has emerged.

1.2 This study by a team from the Scottish Hospital Centre reviews a representative sample of day hospitals for geriatric patients in Scotland with a view to clarifying the objectives and formulating design guidance. The principles of planning set out in this document, although related particularly to the design of new buildings, may also be applied to premises which are to be upgraded or adapted for day hospital purposes.

1.3 The work was undertaken by a multi-professional team comprising: the Director, Mr J Leithead; Nursing Officer, Miss F G Macdonald; Medical Officer, Dr D M McLellan; Architect, Mr A N Simpson. The team gratefully acknowledges the help received from many officers of the hospital service and in particular from the staff of the day hospitals in which the studies were carried out.

CHAPTER 2 : THE BACKGROUND

Previous studies

2.1 In 1961 Farndale[1] reviewed the origin, history and location of all types of day hospitals at that time in the United Kingdom. During the next decade a number of new units were developed in new or altered buildings. A number of papers were published in a variety of journals but most dealt with the experience gained in individual units, particularly from the clinical and functional point of view. Towards the latter part of this period a comprehensive review of geriatric day hospitals in England and Northern Ireland was published in 1970[2]. The conclusions provided a summary of the position at that time.

2.2 From the point of view of producing positive advice about the function and design of geriatric day hospitals, particular attention may be drawn to three papers:-

a "Outline Information for the Geriatric Day Hospital" which was published by the Birmingham RHB. This provides information about the operational policy, a schedule of accommodation, room data sheets, ward layouts and description of the building. The building and the engineering services are also discussed[3]

b A basic functional plan and limited description for a geriatric day hospital, published by the Sheffield RHB in 1969[4]

c A shortened version of a working party report, prepared by the SE Metropolitan Hospital Board whose remit was to review the geriatric services in that region[5].

2.3 Other sources of reference material of value are:-

a The note of the meeting on day hospitals held at the Scottish Hospital Centre on 17 March 1967[6]

b A memorandum prepared by the "Scottish Branch of the British Geriatric Society" which considers the place for day hospitals, day clinics and consultative health centres in the geriatric service[7].

Number of places required

2.4 The predictions of the Registrar General for Scotland about population increases by age groups up to 1988 for Scotland are -

	1968		1988		Increases	
	No	% of total pop.	No	% of total pop.	No	%
Total population	5,217,000	-	5,509,000	-	292,000	5.6
No aged 65 and over	608,000	11.7	692,000	12.6	84,000	13.8
No aged 70 and over	373,000	7.2	455,000	8.3	82,000	22.0
No aged 75 and over	206,000	4.0	277,000	5.0	71,000	34.5

These figures clearly indicate that there will be an increased demand for all services for the elderly, including demands on the geriatric, general medical and psychiatric services. Increased provision of day hospital facilities is likely to be one of the measures to meet the needs.

2.5 As a result of discussions which have taken place between the Scottish Home and Health Department and the Department of Health and Social Security it has now been agreed that the interim target for the number of geriatric day hospital places should be 2.0 per 1,000 people aged 65 or over by 1968 (a total of 1,384 places for Scotland). This target figure continues to be a matter of discussion.

any figures of this type would represent use, rather than need.

2.6 The size of a geriatric day hospital will vary in relation to the population served. Many of the day hospitals currently in operation have a relatively small number of places - around about 12 or so - this may be a reflection of the fact that a relatively low priority has been accorded to this type of development. Review of the literature suggests that the optimal size should provide for 30-50 places. The arguments for this are based on the following reasons:-

a economy of scale and capital costs

b concentration and economy of staff

c transport arrangements

d maintenance of an informal atmosphere

In this context different problems arise in urban, semi-urban and in rural areas.

Role and objectives of a geriatric day hospital

2.7 In considering the problem it is important to have a clear understanding of the role of a geriatric day hospital. It is to

provide, on a day basis, diagnostic and therapeutic facilities, including rehabilitation, nursing care and diversional activities for elderly patients who are predominantly physically infirm or disabled. The patients spend a substantial part of their day under a therapeutic regime varying from one to five days per week but they return to their own homes or hostels at night. Geriatric day hospitals are directed by consultants in geriatrics or in general medicine.

2.8 Geriatric day hospitals must be distinguished from other types of specialised day units in hospitals, eg psychiatric day hospitals and day hospitals for the mentally subnormal, although it is possible that these units may have some factors in common with geriatric day hospitals. Other types of hospital care on a day basis include short-stay and day beds associated with general hospitals: these present very special problems affecting a number of specialties and a need to be linked with specialised supporting accommodation.

2.9 Geriatric day hospitals also need to be distinguished from day centres for the elderly and infirm, psychiatric after-care centres and day centres for the mentally subnormal where the activities are predominantly social and diversional. These centres are more likely to be the responsibility of social work departments and organisations. Hospital medical rehabilitation day centres and industrial rehabilitation units provide different types of specialised services on a day patient basis and present different problems which should be considered in the wider context of "rehabilitation" and in the light of recommendations of the "Mair"[8] and "Tunbridge"[9] reports.

2.10 The main objectives of a geriatric day hospital are to support the in-patient and out-patient services by:-

a allowing more extensive assessment and diagnostic procedures to be undertaken than can be performed on a conventional out-patient basis

b preventing admission, by management on a "day patient" basis

c allowing the earlier start of diagnostic and therapeutic procedures for patients who are awaiting admission

d providing an intermediate environment for in-patients prior to their discharge home

e permitting the earlier discharge of in-patients

f supervision, and continuing therapy of patients who have been discharged

g providing an area in which relatives can receive instruction to assist them with the management of patients in their own home.

It is important that a day hospital should have a discharge policy and that if there is to be a positive therapeutic approach in geriatric day hospitals there must be a close liaison with members of the professions supplementary to medicine, particularly those in the remedial fields. The day hospital should not develop into a day centre.

2.11 To meet the main objectives in an ideal situation the following activities are likely to be undertaken in a geriatric day hospital:-

a *Medical* - consultation, examination and the performance of simple diagnostic and therapeutic procedures

b *Nursing* - basic and technical nursing procedures, including dressings, bathing and the administration of drugs

c *Occupational therapy* - recreation, light industrial activities and rehabilitation in daily living

d *Physiotherapy* - simple individual and group exercise of a preventive, re-educational and rehabilitative type

e *Speech therapy*

f *Individual specific treatment*

g *Chiropody*

h *Dental inspection and treatment*

i *Consultation* - with doctors, social workers, health visitors, medical auxiliaries, chaplains, voluntary workers etc.

j *Provision of refreshments and main meals*

k *Instruction of relatives in home management and after-care*

l *Hairdressing*

m *Social and group activities*

n *Washing of soiled clothing*

These activities will normally take place between 9.0 am and 5.0 pm, Mondays to Fridays, inclusive.

CHAPTER 3: THE STUDY

3.1 Following the team's preliminary assessment of the position in Scotland, eight day hospitals were selected for detailed study. Two large units of up to 50 places in modern purpose-built accommodation, were closely associated with in-patient assessment units serving urban areas. Two smaller day hospitals were associated with in-patient assessment units, serving urban areas, but in adapted buildings. Another of similar size and type served a semi-urban area. One large day hospital, in adapted premises and associated with long-stay beds served an urban area. Two small units, in adapted accommodation and associated with small long-stay units, served rural areas.

3.2 The team visited each day hospital for the whole of a working day. Detailed information was obtained covering the following points:-

a accommodation and equipment available

b general information about relationships with the main hospital unit, working hours, area and population served and travelling time of patients

c transport arrangements

d weekly timetable

e administration, including criteria for admission, contact with general practitioners, hospital and community social workers and other hospitals, arrangements for admission, review, discharge and follow-up and records

f activities undertaken, with number of patients involved, frequency and location

g medical and nursing information about the dependency of patients attending on the day of the visit, confirmation being obtained that they represented a typical sample of the total patient load

h comments of the medical and nursing staff and the remedial therapists.

3.3 Following the visits, the team consolidated their findings in summary form as set out in Chapter 4. Detailed information about the individual day hospitals visited is in Appendix II and in Appendix III there is set out data about patients attending the day hospitals at the time of the team's visits.

CHAPTER 4: SUMMARY OF FINDINGS AND DEVELOPMENT OF ACCOMMODATION REQUIREMENTS

4.1 On the basis of the main objectives outlined in paragraph 2.10 there is scope for further development of day hospital facilities in Scotland to supplement the in-patient, out-patient and local authority services for the aged.

4.2 Day hospitals are not a substitute for in-patient care. They are a complementary activity, representing to some extent a new development. The relief which may be afforded to in-patient units is difficult to quantify and estimates should be scrutinised with care. It was suggested to the study team that 20 places in a day hospital might be equivalent to about 5 beds in a geriatric assessment unit but this cannot be proved because of a variety of factors - mainly differences in the physical facilities and the varying patterns of the geriatric services.

4.3 Because of variation in standards of building and equipment currently available there are differences in the pattern of activity in existing day hospitals. These are further modified by the differing views and practices of the staff involved and the resources available to them. Consequently the operational policies showed some variation.

4.4 The siting and scale of accommodation required depend upon factors which are to some extent interrelated eg

a the age distribution of the population served

b the demographic nature of the area in which the day hospital is to be located and, in particular the population spread

c the proximity of an assessment unit or long-stay beds and other hospital facilities eg radiological and remedial therapy departments.

4.5 Remedial therapy presents a special problem. In the larger geriatric units there are likely to be existing departments which are staffed and facilities can be shared. In the smaller units it is unlikely that continuity of staffing can be ensured. Whilst it is accepted that there are arguments for having remedial staff exclusively allocated to such day hospitals, it is considered that there would be advantages in pooling these limited resources on a hospital group or local authority basis for 3 main reasons:-

a the shortage of staff in these categories

b the need to make the maximum use of resources

c it is desirable that junior staff gain as wide a spectrum of experience as possible.

This is not to say that a senior remedial therapist should not have specific responsibility for a section of a day hospital.

4.6 This suggests that geriatric day hospitals should have close physical and organisational links with major components of the geriatric service and of the general rehabilitation services. There is a need for close liaison with the services provided by the local health and social work departments for whom accommodation may be required within the day hospital.

4.7 Taking all these factors into account there seems to be a need for 3 main types of day hospital:-

a Major

This type is closely associated with an assessment and long-stay unit, with up to 200 beds, out-patient facilities and supporting diagnostic and therapeutic services. Such a day hospital might have places for 30-50 patients. They may be associated with district general hospitals.

b Intermediate

In this situation, the assessment unit is likely to be remote but a number of long-stay geriatric beds or other hospital facilities are likely to be on the same site. Diagnostic, therapeutic and supporting services are likely to be more limited than in the major type. Depending upon circumstances, 15-30 places might be required.

c Minor

Here, the day hospital is likely to be in a semi-rural area and associated with a limited number of long-stay beds and is remote from elaborate diagnostic services. The number of day places would vary from 10-15. Although small, active diagnostic and therapeutic objectives must be maintained.

In all 3 types, medical, nursing and remedial activities must be integrated with those of the geriatric service for the area. There appears to be a need for closer integration with the social work services in view of their interdependence but this is mainly an organisational matter.

4.8 At an early stage in the study it was appreciated that there should be close functional links between geriatric day hospitals and day centres for the elderly and infirm if a positive therapeutic approach was to be maintained in the former. Closer co-operation with those bodies responsible for management of day centres is necessary.

Provision for services and functions

4.9 To meet the necessary functions there has to be provided:-

a accommodation

b services

c equipment, and

d staff

4.10 All of these have to be welded together to form an efficient working organisation. This report is primarily concerned with accommodation which may be considered under the following broad headings:-

Accommodation for -

a patients

b functions directly concerned with patients, and

c other functions

In the following paragraphs, the type of accommodation to meet these functions is discussed. From this emerges the basic list of rooms and spaces required. Summaries of these elements of accommodation with an indication of function, furniture and equipment, services, suggested dimensions, and required relationships to other areas are at Chapter 7.

Accommodation for patients

4.11 For their attendance at a day hospital patients' basic requirements include transport, reception arrangements, clothes storage, day activity spaces, WCs, bathrooms, and a rest room.

4.12 Travelling arrangements The travelling times for patients to travel from their homes to the day hospital and for the return journeys estimated by the staff were less, as a general rule, than the times given by the ambulance drivers. All the staff agreed that no patient should spend more than 1 hour in an ambulance at a time and that, if possible, travelling should be completed within a much shorter period.

4.13 Transport is particularly a matter of organisation, but problems can be simplified by special attention being paid to the arrangement and accommodation for the reception of patients. Adequate secretarial assistance for making arrangements for transport is important. The type of transport used seems to merit special study to determine the most suitable type of vehicle.

4.14 Entrance The entrances seen on the study varied greatly. Even in the purpose-built day hospitals, the canopies and doors were not entirely satisfactory. Most of the entrances to the modified buildings were unsatisfactory with the consequence that delays and bottlenecks occurred in getting the patients into and out of the day hospitals.

4.15 Entrances should be protected from the elements by overhead canopies to provide cover and shelter for patients and their attendants on leaving and entering ambulances and other vehicles.

4.16 Entrance hall Entrance halls generally had insufficient space for the assembly and movement of patients on arrival and departure and for the storage of wheelchairs and walking aids. Difficulties arose,

particularly in the larger units, if it were not possible for staff in the working areas to observe the arrival of ambulances because porters were not always readily available, if the route to the day area was not direct and if it exceeded 30m (100 ft) - the shorter the distance between the main entrance and the entrance to the day activity space the better.

4.17 The principal functions of an entrance hall are to provide facilities for the assembly of patients on arrival and departure, and to store wheelchairs and walking aids. There will be sufficient space to accommodate up to one-third of the patients attending daily, 2-4 staff and 2-4 wheelchairs depending on the size of the day hospital. If the entrance to the day hospital is also to be the main entrance to an associated in-patient area it may be necessary to provide a room for a porter.

4.18 Reception and records office The absence of an office for reception and records, to receive visitors and to carry out clerical and secretarial work for the unit in many of the day hospitals visited was a distinct disadvantage. In most units, records used for day patients were incorporated in a group records system. This arrangement seemed to work well and was valuable to the staff as it provided comprehensive medical information about the patient.

4.19 An office will be required for the reception of visitors, to carry out clerical and secretarial work for the day hospital and to store current records. It will be located adjoining the entrance hall.

4.20 Patients' clothes storage The arrangements for the storage of patients' outdoor clothes varied greatly. The lack of space to allow patients to remove and put on their outdoor clothing with or without assistance, the lack of reasonable security for storage of these clothes and a simple method of identification of the garments caused difficulties.

4.21 A room or bay in which patients may remove, store with reasonable security, and put on outdoor clothing is required; this room or bay should be adjoining and observed from the day activity spaces.

4.22 Day activity spaces Considerable variations in space standards were observed in the various day activity spaces. In the larger units separate day and dining areas were provided. In the smaller units these functions were in some instances undertaken in the same area and in addition diversional and recreational activities took place. It was clear that where there were fewer supporting facilities eg remedial therapy departments, more space was required in the day activity area.

4.23 Day room facilities are required for sitting, eating, talking, reading, watching television, listening to radio and diversional therapy. There is clearly an incompatibility between some of these activities and there should be some separation of them rather than catering for all in a single room. As almost all patients receive a mid-day meal dining space is required for the number of patients attending on a daily basis; this space, together with the main day room space, should be capable of being used for other purposes, eg film shows and concerts for in-patients in the main geriatric unit.

4.24 Sanitary facilities Many of the WC compartments seen were too small for assisted toileting. In some cases the area provided was adequate but because of poor positioning of the sanitary fittings and grab rails access for patients with walking aids or wheelchairs was difficult. The position was further complicated by the shortage of WC compartments at distances convenient for the patient, and because of the lack of suitable nurse working rooms some were used for bagged material awaiting disposal, miscellaneous items and dirty linen.

4.25 The WC is a facility which is of prime importance, particularly to the elderly in day hospitals. Because many patients have to be assisted to and in the WC compartment it is advantageous to have these compartments central to the day activity spaces, the nurse working rooms and the remedial departments. There should, for hygienic reasons, be a hand-rinse basin in every WC compartment. With suitable location of the fittings and fitments and the provision of outward opening doors an area of 2.8m^2 (30 sq ft) should provide sufficient space for handicapped patients with assistance.

4.26 In some units if patients required bathing they had to be taken to a nearby ward. Bathrooms were available in the purpose-built units but the detailed design could have been improved. Some of the other units had bathrooms but most of these were unsatisfactory in detail.

4.27 One bathroom with a free-standing bath should be provided for approximately 20 patient places, with a maximum of 2 in units of up to 50 places. The bathroom is located convenient to the nurse working rooms.

4.28 Rest room A rest room for patients was available in the two purpose-built units. In one of the larger modified units a room used for consultation and other purposes could be used if necessary. Otherwise no special provision was available in the other units.

4.29 In larger units a rest room will be necessary: it should be in the form of a single bed room, be close to the nurse working rooms and be capable of being supervised by nurses going about their duties.

Accommodation for functions related to patient care

4.30 The scale of provision for nursing and remedial activities varied greatly in the units studied, caused partly by the accommodation available, partly by the availability of trained staff, and partly by facilities being provided elsewhere on the hospital site.

4.31 While to some extent the provision of accommodation for remedial activities will have to be considered on an individual basis and only general guidance can be given, it is clear that suitable accommodation is required for nursing work which consists basically of:-

a receiving or reading instructions

b collecting together and preparing items for the necessary procedures

c carrying out the procedures

d disposing of waste and used items

e recording what has been done

The more this circuit of activity can be concentrated, the more convenient will it be for nurses. The preparation functions, disposal functions and recording functions should be grouped in individual rooms and in turn these rooms should be grouped together: these constitute the essential nurse working rooms.

4.32 Nurses' station Nurses' stations were only observed in the purpose-built day hospitals. Otherwise, nurses used desks and writing surfaces of different types in the day activity spaces or associated circulation areas. These arrangements were unsatisfactory and produced difficult working conditions for the nursing staff.

4.33 The nurses' station is the base from which nurses work and at which they may receive or read instructions and record procedures in the nursing records held there. For ease of supervision of patients the nurses' station may be located in the day activity spaces.

4.34 Sister's/Charge nurse's office Offices for the sisters or charge nurses varied. In a purpose-built unit the office was isolated from the main working area. In one of the modified units it was some distance from the day hospital and located in an out-patient department. Two of the modified units had no office.

4.35 An office is required in which to organise the work of the section; this includes writing notes, consulting records and speaking to groups of staff. The office should be adjacent to the nurse working rooms.

4.36 Preparation room It was only in the two purpose-built buildings and in one of the larger modified buildings that preparation rooms were seen otherwise clean material was stored in cupboards, shelves or any convenient space which was available. In the majority of the units visited provision for preparation room functions was inadequate and unsatisfactory.

4.37 The preparation room* is the storage place for all supplies, clean and sterile, necessary for the care and treatment of patients. It provides space for the preparation and assembly of items of equipment for nursing, diagnostic and therapeutic procedures. In addition, it provides storage space for trolleys required to transport equipment to the point of use, treatment room and bathroom. Trolleys serve the dual role of work-top and conveyor. The storage space for all items kept in the preparation room should be calculated on the basis of a topping-up system.

4.38 Disposal room The two purpose-built units had disposal rooms - and in the others a variety of rooms were used, including patients' WCs.

4.39 The disposal room is the temporary storage point for all items of equipment which have to be removed for cleaning, reprocessing or destruction, eg linen, CSSD items, etc. Some items are cleaned in this room, eg trolleys, before return to the preparation room.

* See Scottish Hospital Centre Information Sheet "Preparation Room"

4.40 Sluice/test room Sluice and test rooms were seen in the purpose-built units and in one of the modified buildings. The sluice and test room in the modified building was some distance from the main working areas. In the other units where testing was done, wards or other adjacent facilities were used. In some, it was impossible to undertake any testing at all.

4.41 Sluice room functions are unpleasant: they should be accommodated separately from the disposal room. The room also serves as the temporary storage point and testing area for some specimens. Bedpans with their carriers, urinals, etc have to be stored here.

4.42 Pantry The pantries seen varied considerably. Some were well laid out but others presented difficulties to the staff in serving meals and light refreshments to the patients. In some instances the patients were using the limited facilities available to prepare meals as part of training. Where this was done in the Aids to Daily Living (ADL) section of an occupational therapy department it was noted to be more satisfactory, allowing the staff to provide beverages and meals to the remainder of the patients more efficiently.

4.43 On the assumption that all main meals will be provided in bulk or plated in central catering departments, from which routine beverages will also be distributed and where dish-washing will be centralised, a pantry will require to store only a limited quantity of crockery and cutlery and allow for preparation of occasional beverages.

4.44 Treatment room Treatment rooms were provided in the two purpose-built units but although plaster was used in these rooms, plaster traps had not been provided. In one of the large modified buildings a multi-purpose treatment room was used by nursing staff, doctors and dental staff. Otherwise facilities for treatments were very poor.

4.45 The function of a treatment room is to provide the right environment, including privacy, for patients undergoing therapeutic and diagnostic procedures and patient education. For supply and disposal of equipment it is necessary for it to be located conveniently close to the preparation and disposal rooms.

4.46 Wheelchair/sani-chair bay Storage facilities for wheelchairs/sani-chairs was limited and in some cases non-existent. In the two purpose-built units chairs were stored in main corridors, in some others they were located in entrance halls or tucked away at inconvenient points for use.

4.47 A broad-fronted shallow storage area for wheelchairs and sani-chairs will be necessary and should be located between the entrance and the day activity spaces.

4.48 Consulting/examination room Consultative suites were adjacent to the day hospital in the two purpose-built units; this facility was valuable. In one of these a busy consultative session complicated traffic within the day hospital. In one of the larger modified units a consultation room was available but in the remainder consultation and examination had to be undertaken in an out-patient department, or in a ward, usually some distance from the day hospital.

4.49 A consulting/examination room* to enable a doctor to take histories, interview, examine and assess patients, dictate correspondence, and hold staff discussions will be necessary only if there are no such facilities in the adjacent main hospital.

4.50 Interview room Interview rooms were only available in the two purpose-built day hospitals. The absence of this facility in the remainder of the day hospitals was a disadvantage.

4.51 A room is required in which staff may interview patients, relatives and other visitors.

4.52 Occupational therapy Facilities for occupational therapy varied considerably. In the larger units, particularly those which were purpose-built, good facilities were available although minor defects in detail were noted. In the smaller units only simple diversional and recreational activities could be undertaken in day activity spaces. In some instances nurses participated in these activities. It was noted that shortages of occupational therapy staff limited the full utilisation of the facilities which were available.

4.53 Occupational therapy as provided in a geriatric day hospital is the treatment, under medical supervision, of mainly physical disorders by means of specially adapted crafts and other forms of productive work and recreational activities to assist the recovery of locomotory and sensory functions. Although there is scope for craft work which is mainly diversional in character there is a tendency towards activities, which both from a domestic and an occupational standpoint are more closely related to the patient's life in his own home; this has an important bearing on the accommodation required. The department, in conjunction with the physiotherapy department, will in the great majority of cases undertake medical and social rehabilitation of patients to enable them to live in their own homes. The occupational therapy department may provide treatment for both in-patients, out-patients and day hospital patients. In view of the physical disabilities of many of its users, it should be at ground level and easily accessible from the day activity space and bed areas of the main hospital. Where a change of level is necessary, steps should be avoided and ramps with suitable gradients provided.

4.54 Two main types of room will be needed for treatment:

a *Light workshop* providing light handicraft work

b *Domestic section* for the training of disabled patients in the activities of daily living

4.55 Occupational therapy and physiotherapy should be in adjacent areas and in close relationship to the day activity space which will be utilised by both departments for diversional and recreational activities. Many disabled patients need to be rehoused and educated in normal daily activities such as bathing, working in the kitchen, use of the WC and getting in and out of bed.

* See Scottish Hospital Centre Information Sheet "OPD Consulting/ Examination Room"

4.56 Physiotherapy department As with occupational therapy, facilities for physiotherapy varied considerably and staff shortages limited the full utilisation of resources. In the smaller units where no physiotherapists were available nursing staff used simple equipment to help patients regain lost mobility.

4.57 The physiotherapy department may provide treatment for both in-patients and out-patients. The treatment is broadly of 2 types - active, in the form of group and individual treatment, mainly of a remedial character in an exercise area, and individual passive treatment, including massage, manipulation, heat and assisted movements and various forms of electro-therapy, given as a rule in cubicles. The department should, wherever possible, be at ground level and conveniently sited for access by patients from the day hospital and from bed areas in the main hospital. In view of the physical disabilities of patients using this department, where a change of level is necessary, steps should be avoided and ramps with suitable gradients provided.

4.58 Speech therapy department Speech therapy was available in three of the day hospitals. In one instance this was part of an area service, in another specifically for the geriatric service and in the third was provided by the local authority on a sessional "repayment" basis.

4.59 Unless the day hospital is a major centre for a speech therapy service, when special accommodation will have to be provided, provision will be limited to modification of an interview room by sound reduction and other minor alterations to provide facilities for intermittent use. It is likely that this form of therapy will assume increasing importance in the future.

4.60 X-ray department In the two purpose-built day hospitals radiodiagnostic facilities were available but these were used mainly by in-patients and out-patients and only to a very limited extent by patients attending the day hospital. Where the day hospital was associated with a larger hospital complex there was access to a radiodiagnostic department elsewhere in the hospital but the number of referrals to it from the day hospital was small. The smaller day hospitals did not have x-ray facilities on the site.

4.61 It does not seem necessary to provide x-ray facilities exclusively for a day hospital, but it should be possible to refer patients to a radiodiagnostic department without difficulty. This is an organisational problem.

4.62 Dental surgery and chiropody room The two purpose-built day hospitals had dental suites adjacent to the day activity spaces but both these were under-utilised although the majority of the work came from the in-patient areas associated with these units. In one modified building a dental unit had been installed in the treatment room; this arrangement had proved satisfactory. The remaining day hospitals had access to dental services either within the hospital complex in which the day hospital was located or by using general dental practitioners. It was noted that the referrals to dental services from the day hospitals was relatively low.

4.63 All the day hospitals had access to a chiropodist but where accommodation had been allocated exclusively for this purpose it was significantly under-utilised. It was noted that this was a valuable and important service to the elderly patients.

4.64 There is a need for dental services and chiropody but, in view of the frequency of demand for these services in any given period, it will be difficult to justify the allocation of accommodation exclusively for these services in a day hospital. Although at present there is reluctance for these services to share accommodation the possibility should be explored.

Accommodation for other functions

4.65 Hairdressing salon Hairdressing salons were provided in the two purpose-built hospitals: they were also used for in-patients. In the remainder, hair was either washed in the bathroom of the day hospital or patients requiring it were referred to an adjacent ward.

4.66 In day hospitals with more than 15 places a room will be provided for the washing, drying and setting of patients' hair: the room may also be used for in-patients.

4.67 Equipment store Storage accommodation was generally inadequate and when provided was often of poor design making it difficult of access to items stored.

4.68 Only essential working stocks should be stored in the preparation room. A store is required for bulky equipment and apparatus such as folding wheelchairs, walking aids, etc.

4.69 Domestic service room Apart from the provision in the two purpose-built units, accommodation for domestic services left much to be desired.

4.70 A room* is required for the storage and cleaning of domestic equipment.

4.71 Staff cloakrooms Good quality accommodation for staff cloaks and WCs had been provided in the two purpose-built units but even in both of these space and locker accommodation for females was slightly inadequate in view of the number of part-time staff employed. In the remainder of the day hospitals this accommodation was grossly limited and of a poor standard.

4.72 It is assumed that central changing accommodation will be available for non-resident staff and that only cloaks and small personal items will be kept in the staff cloakrooms in the day hospital. WCs will be associated with the staff cloakrooms.

4.73 Staff conference and common room Staff conference rooms were only provided in the two purpose-built day hospitals. The staff of the majority of the remainder of the day hospitals met regularly but had to do so in an area outwith the day hospital.

* See Scottish Hospital Centre Information Sheet "Domestic Service Room"

4.74 It is assumed that a room outwith the day hospital will be provided for medical and nurse teaching and for staff seminars.

Staffing

4.75 As the range of facilities, activities undertaken and relationships with other hospital departments differed in the day hospital, different staffing structures were apparent. Comparisons are of limited value but are given in Appendix IV.

4.76 Medical activities in the day hospitals were greatest where there was close association with an assessment unit and a consultative out-patient clinic. Similar considerations apply to other professional activities.

4.77 The nursing activities observed covered a wide range which varied from day hospital to day hospital. These activities included the bathing of patients (both continent and incontinent), dressing small wounds and ulcers, removal of sutures, weighing, administering medicines, suppositories and enemata, collection of samples of urine and stools, washing soiled clothing, working jointly with the remedial therapists, providing recreational and diversional therapy and providing assistance with feeding in addition to general supervision of the patients from the time they entered the day hospital until they departed. In some instances the nursing staff went with the ambulance to collect the patient from his home and also on the return journey.

4.78 It was clear that the nurses played a key role in the running of the units. In addition to practising their special skills for which they required back-up facilities which in many instances were lacking, they co-ordinated the activities of the day patients and provided continuity of care. Account should be taken of the value of nursing staff travelling with the patients: local circumstances will dictate the detailed arrangements.

4.79 Remedial therapist staffing figures, shown in Appendix IV, were provided by the staff concerned and represent availability rather than need.

4.80 The pattern of social work and co-operation with local authorities varied to such an extent that the staffing levels for social workers have not been considered in detail.

4.81 The efficient operation of a day hospital of any size requires secretarial assistance of good quality. As the secretarial arrangements of the units visited varied so much, no reference is made to this aspect of the problem.

4.82 The domestic service was noted but not studied in detail.

CHAPTER 5: PLANNING AND DESIGN REQUIREMENTS

5.1 Availability of a day hospital linked functionally to a geriatric hospital offers an alternative to in-patient admission for patients who do not require 24-hour care and supervision. It may also be used as a step forward in progress for in-patients who have recovered sufficiently to leave the in-patient accommodation.

5.2 The day hospital need not necessarily be part of the geriatric hospital building. However the advantages of close functional relationships diminish with increased physical separation and therefore for preference the day hospital should be fairly close to the in-patient areas and easily accessible to patients, who should not be obliged to enter the in-patient areas in order to reach the day hospital.

5.3 To provide adequately for specialised patient activity and diverse daily routine the accommodation should be restricted as far as possible to ground floor level regardless of building location. Clinical areas apart they should be domestic in scale and atmosphere. Although intensive therapeutic activity is envisaged building and equipment materials, fittings and finishes should be aesthetically pleasing and promote comfort, but should also be robust, economical to maintain and, as far as possible, fire-resistant. Floor finishes where non-carpeted should be non-skid and resilient. The use of non-stain fitted carpeting throughout both the day and dining spaces is recommended.

5.4 In all offices, consulting/examination and interview rooms, transmission of sound through doors, partitions, etc should be minimised. The use of sound absorbtive finishes is recommended on ceilings throughout the day hospital.

5.5 All furniture, free-standing or built-in should be simple, capable of easy cleaning and free from dangerous corners and edges. No table should be lower than dining height. WC compartments should be carefully considered and should be designed in accordance with nursing practice. The compartments should not open directly off rooms or corridors, but should be entered from a lobby. Cubicle doors should open outwards.

5.6 Day activity spaces should be located to ensure a source of interest. Window sill heights in both day and dining spaces should be kept low to ensure that seated patients may enjoy the view or, more important, the passing scene.

5.7 Landscaping and decorative treatment of the spaces around the building will be essential as the therapeutic environment of the day hospital should be reflected in its immediate physical surroundings. Some areas should be laid out for occupational therapy gardening and sitting out. Access to outdoor spaces should be provided from a number of locations, in particular the day activity spaces and the occupational therapy department.

5.8 The need for adequate fire protection of the building should be taken into consideration in the design of the building and of the engineering services, especially ventilation schemes. These requirements should be considered during the early stages of design. Reference should be made to the appropriate Hospital Design Notes and Technical Memoranda on protection against fire and fire precautions, and also to the Building Standards (Scotland) (Consolidation) Regulations 1971. Advice on the fire fighting installations proposed should be sought from the local fire authority.

5.9 Storage provision for wheelchairs, trolleys, walking aids etc should be positioned in such a way as to enable fire exits at all times to be kept clear.

5.10 Provision has to be made in the day hospital for storage and administration of drugs.

CHAPTER 6 : ENGINEERING SERVICES

General considerations

6.1 The engineering services should be designed and installed to ensure ease of maintenance and minimum of interruption of services and working of the day hospital while repairs, maintenance and extensions are being carried out.

6.2 Facilities should be provided for the easy installation of meters in case they may be required at any time for departmental costing purposes.

6.3 Areas should be designed so that most rooms can be naturally ventilated and during the daylight hours reliance placed mainly on natural lighting. Mechanical ventilation should be restricted to a few rooms. Exceptional factors such as the depth, height and siting of the building as well as para medical and nursing requirements may necessitate more extensive mechanical ventilation and artificial lighting. Deep plan spaces may need supplementary mechanical ventilation.

6.4 Users' requirements and working arrangements should be carefully considered in placing service outlets.

6.5 Facilities required for commissioning purposes must be allowed for in the detailed design of services. Ease of access to engineering controls is important for this purpose and for ease of maintenance, and these controls should be sited in circulation areas rather than working areas wherever practicable.

6.6 The problems of production and transmission of noise should be carefully studied in the design of any ventilation system and in preventing noise from the workshop being transmitted at an unacceptable level to adjacent areas.

6.7 If a workshop is provided the local Inspector of Factories must be consulted about the arrangement and guarding of any power operated machines and the provision of appropriate dust extraction equipment to ensure the safety and welfare of patients and staff in the workshop.

6.8 Special care should be taken to avoid features which might cause injury to the elderly patients.

Mechanical services

6.9 Heating The space heating system should be designed so that it can be run at reduced level to save fuel when the day hospital is not in use, either at night or during weekends. Sufficient heating should be provided at all times to prevent excessive condensation on walls; this can usually be achieved by ensuring a minimum temperature of 10°C (50°F).

6.10 Zoned temperature control of the heating system may be needed to allow for widely varying heat loss conditions, this applies especially where the building has a high proportion of glazing.

6.11 Space heating requirements should be calculated on the design temperature and ventilation rates listed below, based on an outside temperature of -1°C (30°F).

Accommodation	Temperature	Air changes per hour
Treatment room	24°C (75°F)	6
Entrance	21°C (70°F)	3
Day activity space	"	"
Nurses' station	"	"
Patients' rest room	"	"
Treatment room	"	"
Consulting/examination room	"	"
Dental surgery	"	"
Chiropody room	"	"
Light industrial workshop	"	"
Aids to daily living section	"	"
Physiotherapy - active and passive treatment areas	"	"
Reception and records office	21°C (70°F)	2
Preparation room	"	"
Bathroom	"	"
Office	"	"
Hairdressing salon	"	"
Interview room	"	"
Staff cloakrooms	"	"
WC compartments	"	"
Patients' cloaks bay	16°C (60°F)	(a)

Accommodation	Temperature	Air changes per hour
Pantry	16°C (60°F)	2
Disposal room	"	"
Sluice and test room	"	"
Domestic service room	"	"
Store	10°C (50°F)	½

(a) sufficient air circulation for drying patients' outer clothes; 6 air changes per hour will usually be sufficient.

6.12 A conventional low pressure hot water heating system which has low installation and maintenance costs should be suitable for use in most areas of the day hospital.

6.13 Heating surfaces should normally be placed below windows and against exposed walls to counteract cold air currents. If surface mounted heating equipment is used it should be fixed with sufficient clear space below to allow for use of floor maintenance equipment.

6.14 Any exposed heating surface at a height of less than 2m (6'6") should be guarded if the temperature of the surface greatly exceeds 49°C (120°F). This limit of temperature need not be exceeded with conventional low temperature hot water heating installations if convectors are used. Radiant type convectors provide an alternative solution since they give a reasonable proportion of their output in radiant form but as they use plain instead of finned tubing they do not present the cleaning problem associated with conventional convectors: they are designed to operate at the normal heating system pipe temperatures but the temperature of their surfaces is of the order of 49°C (120°F).

6.15 Where ceiling heating systems are used they should conform to the recommendations of the Medical Research Council's Environmental Research Unit. These may be found in the "Guide to Current Practice" of the Institution of Heating and Ventilating Engineers.

6.16 Underfloor heating is not likely to be a satisfactory form of heating for this type of accommodation.

6.17 Day spaces may have radiant type electric fires with suitable guards. Electric heaters should not normally be required elsewhere but where they are provided and where patients can come into contact with them they should have low surface temperatures or suitable guards, the electric elements being totally enclosed and the heater permanently fixed and connected to the electricity supply.

Ventilation

6.18 The day hospital should normally be naturally ventilated but some mechanical ventilation may be necessary to provide satisfactory conditions in certain circumstances. Factors which will influence the need for mechanical ventilation are deep planning of floors, depth of perimeter rooms, extraneous noise and air pollution.

6.19 Core areas of deep planned floors would normally be mechanically ventilated to ensure that internal heat gains are removed. If excessive air change rates are required for this purpose it may be necessary to provide refrigeration plant to cool the incoming air. Conditioning plant of this type is expensive both to instal and to operate and its provision should not be contemplated without a full appraisal of the design factors leading to that requirement. Perimeter rooms should usually be naturally ventilated but those which cannot be cross ventilated effectively by natural means should be mechanically ventilated to augment the natural ventilation to give a rate of 3 air changes per hour. In such rooms care will be required in locating the diffusers and grilles in order to prevent the formation of stagnant pockets of air at the most distant point from the windows.

6.20 In deep planned floors, peripheral corridors which are open along their length to natural ventilation areas should be assumed to be naturally ventilated but corridors separated from natural ventilated areas by walls and doors should be mechanically ventilated; 6 air changes per hour should be adequate. Where mechanical ventilation is provided the general air movement should be from clean to dirty areas, where these can be defined, and therefore there should be no re-circulation of air.

6.21 Internal rooms should be mechanically ventilated to suit their individual requirements; air inlet grilles will be necessary where ventilation is extract only. Day activity spaces may need to be mechanically ventilated where adequate ventilation is required without opening windows. A ventilation rate of 6 air changes per hour should be adequate in such cases.

6.22 Internal lavatories should have mechanical extract ventilation to give 10 air changes per hour. Some lavatories on external walls may need mechanical ventilation to comply with the requirements of the Building Standards (Scotland) (Consolidation) Regulations.

6.23 Mechanical extract ventilation should also be provided at low level in the disposal and sluice rooms and at high level in the treatment room.

6.24 Some mechanical ventilation may be necessary for the removal of heat, dust etc. produced in the light industrial workshop in the occupational therapy department. Local extract ventilating fans should normally be adequate for this purpose although in some instances dust extracting plant may be provided to meet the requirements of the local Inspector of Factories.

6.25 Care must be taken to ensure an adequate flow of air into any space having mechanical extract ventilation. If fresh air is used for this purpose it must be warmed appropriately but tempered supply air can often be obtained without excessive draught or noise by fitting grilles in doors or walls connecting such spaces to corridors. Arrangements of the latter kind must not prejudice the fire resistance requirements, affect the privacy of conversations or cause unacceptable transfer of noise from one room to another.

6.26 Where mechanical input ventilation is required the fresh air must be filtered and warmed before being introduced, usually at high level, through suitable diffusers designed to avoid creation of draughts. Ventilation plants should include filters of 95% efficiency down to 5 microns to give satisfactory filtration of the incoming air supplies and in order to reduce frequency of replacement of filters where the air is dirty it may be desirable to include additional coarse filters to remove larger particles. Filters must be readily accessible for maintenance purposes.

6.27 External discharges should be carried clear of the building where practicable and protected against back pressure from wind.

6.28 Visible indication should be provided to show when the ventilation is operating. Selection of the most suitable position for indicators should be related to the scope of the ventilation system. For individual units, eg extract fans, the indicator may be incorporated in the control switch. Where a system is provided for a particular room the indicator should be in that room and in the case of more general systems of ventilation, eg core areas, the indicator would probably best be located at the nurses' station.

6.29 Particular care should be given to the type of opening window selected for naturally ventilated areas. Top-opening windows at high level should be provided with a "minimum setting" notch or other adjustment to allow air infiltration without draught. In ceiling heated rooms the incoming air should not be directed at the ceiling.

Water supply

6.30 The domestic hot water supply should preferably be taken from the central supply installation of the main hospital. If this is not practicable a storage calorifier should be provided, with its capacity based on meeting the maximum requirement for 2 hours, and the calorifier battery rating should be based on a 3-hour recovery period, having regard also to the heat losses from the mains; an allowance of 18 litres (4 gallons) per place should provide sufficient storage. The cold water storage should be sufficient for 24 hours' requirements. This would normally be held centrally in the main hospital but it is usual to provide 4-hour storage locally; an allowance of 23 litres (5 gallons) per place per day should be adequate.

6.31 A drinking water tap or point taken direct from the mains or from protected tanks should be provided in the pantry, the aids to daily living kitchen and the dining area. The size of drinking water supply pipes should be kept to the absolute minimum; the pipes should be properly lagged in ducts and voids where they are in close proximity to heated pipes.

6.32 Elbow action taps should be provided in the treatment room and in the preparation, disposal and sluice rooms. Baths and wash-hand basins for patients' use should be fitted with quick filling and emptying fittings, and the hot water temperature should be controlled at a maximum of 40°C (104°F) as a precaution against scalding.

6.33 Cold water pipes passing through warm, humid rooms should be insulated to prevent condensation and consequent dripping; such insulation must be impervious to moisture. This problem can usually be overcome by careful planning of pipe routes.

Town gas

6.34 Gas points in patient areas should be regarded as a potential hazard and provided only where a gas supply is essential. Gas points may be required in the pantry and in the aids to daily living kitchen. Every gas appliance should have a flame failure safety device operating on all burners.

Incinerators

6.35 A collecting system with disposal in a central hospital incinerator is to be preferred to a number of local units, which have the disadvantage that numerous flues will be required which may in some circumstances be too long to be effective; they are often overcharged, resulting in incomplete combustion and leaving an objectionable residue to be cleared, and they entail additional maintenance.

Electrical services

6.36 General requirements The electrical installation should include wiring and equipment for general and special lighting, socket outlets, heating, ventilation, machinery, call systems, telephones and clocks. A bell push system may also be required for the main entrance door.

6.37 Guidance on factors affecting supply and distribution is available in Hospital Technical Memoranda Nos 7, 8, 11 and 14. The electrical installation should comply with the requirements of the current edition of the Regulations for Electrical Equipment of Buildings, issued by the Institution of Electrical Engineers.

6.38 Electricity supply and distribution The supply should normally be provided by sub-main circuits from the main intake and distribution centre to one or more distribution boards which should be situated so as to minimise points of circuit wiring. They should be in well ventilated positions, preferably accessible from corridors. A lock should be

fitted to any distribution board not located in a locked switchroom or cupboard. It is an advantage if the boards can be reached from a standing position. High rupturing capacity (HRC) fuses are recommended for general use. Spare ways and fuses should be provided for later extensions and space should be allowed for additional units. Weather-proof materials and construction should be used for any external installation. If workshop facilities are to be provided a 3-phase supply may be required.

6.39 Artificial lighting When designing the lighting installation and selecting lighting fittings careful attention should be paid to the reduction of glare. Lighting fittings should be of types which are easily cleaned and maintained.

6.40 Tungsten lighting will be generally suitable for lighting fittings which will be used intermittently. Fluorescent lighting will be economical where artificial lighting is required for long periods. It is however essential that fluorescent lighting when used in clinical areas, is of one of the recommended types having suitable colour rendering characteristics for clinical purposes. In such areas the colour chosen for walls, floors and ceilings should be carefully considered by the architect and the engineer to ensure that the decorative finishes are compatible with the colour rendering properties of the lamp and the special distribution of the colours of the primary light source is not unduly altered.

6.41 The recommended illumination values with the limiting glare index is given in the following table:-

Accommodation	Average value of illumination (LUX)	Limiting glare index
Treatment room	300	16
Consulting/examination room Dental surgery Chiropody room Physiotherapy - active and passive treatment areas	200	16
Light industrial workshop Aids to daily living section	200	22
Office Interview room	150	19

Accommodation	Average value of illumination (LUX)	Limiting glare index
Reception and records office Day activity space Patients' rest room	150	
Bathroom Patients' cloaks bay Hairdressing salon Nurses' station Preparation room Disposal room Sluice and test room Pantry Staff cloakrooms	100	
Domestic service room Corridor Entrance WC compartments Store	80	

6.42 Where there is lack of daylight in deep-planned internal rooms and corridors it will be necessary to provide higher intensity of artificial lighting during the day than is normally provided during the hours of darkness. The daylight level of artificial illumination for internal spaces should average 300 lux at working level, except in bathrooms, etc and corridors. In bathrooms, toilets and domestic service rooms an average of 150 lux at floor level will be satisfactory. Corridor lighting should provide illumination for day time use of between 200 and 250 lux at floor level. Lighting designed to these standards of illumination should not provide too great a contrast so that staff moving from one area to another can be expected to adapt themselves sufficiently quickly. It is recommended that the lighting system for these spaces should be designed so that the upper and lower levels of illumination can be readily obtained by local switching arrangements to suit day and night use. Where it is necessary to switch off lamps it is preferable that these lamps be in multi-lamp fittings rather than separate single lamp fittings.

6.43 Local switch control of lighting will usually be satisfactory.

6.44 Fittings should be of domestic design where possible and should harmonise with the room decor.

6.45 In the light industrial workshop lighting for benches should be provided preferably by means of fittings eg fluorescent positioned over the benches. Any portable or adjustable arm type lamp should operate at extra low voltage.

6.46 In compliance with BS 2881 a red indicating light should be provided on each drug cupboard with a parallel indicating light at the nurses' station. These lights should be interlocked with the cupboard to give visual indication when the cupboard is unlocked.

6.47 Socket outlets Sufficient 13 amp universal type switched, shuttered socket outlets, connected to ring or spur circuits, should be provided to allow all portable appliances likely to be used simultaneously to be individually supplied from separate convenient outlets.

6.48 Additional socket outlets approximately 9m (30 ft) apart should be provided as necessary throughout the day hospital, including corridors, to allow for convenient use of domestic cleaning appliances having flexible leads assumed to be 9m (30 ft) long. Recommended scales for socket outlets are included in the schedule of accommodation.

6.49 Socket outlets in the treatment room and nurse working rooms should be preferably at working level or at about waist height; outlets should be flush mounted where possible.

6.50 Other power requirements Fixed appliances rated up to 13 amps should be permanently connected to 13 amp fused spur boxes. Appliances rated in excess of 13 amps should be permanently connected to separate final sub-circuits and independently switched.

6.51 The day activity space should have 2 television aerial socket outlets so that although only one will normally be used the room can be divided as necessary and the set resited without difficulty. Where television sets are installed in the day activity spaces it may be desirable to provide facilities for the sound to be conducted by earphones for a proportion of the patients in order to stop any spread of noise.

6.52 Nurse call systems A patient/nurse call push button, reassurance light and cancellation button system should be installed in each WC compartment for patients. An indicator light should be provided at the nurses' station.

6.53 Telephones Telephone facilities for internal and external calls should form part of the main hospital telephone system and should normally be provided in each consulting/examination room, interview room, reception/records, nurses' station, and in offices. Telephones should normally be of desk pattern and for the nursing station should be fitted with an indicating call light visible from the corridor and a bell of subdued tone which, when desired, may be switched out of circuit independent of the call light.

6.54 Electric clocks Electric clocks will normally be required in the reception/records office, day activity spaces (2), the treatment room and the nurses' station. Clocks should have silent movements and in the physiotherapy department and the treatment room should have sweep second hands which can be driven by a small independent motor if necessary. 230mm (9 inch) diameter dials should be adequate for most situations.

		(a) Major 30-50 places	(b) Intermediate 15-30 places	(c) Minor 10-15 places
COVERED ENTRANCE				
Functions	To provide cover and shelter for patients and their attendants on leaving and entering ambulances and other vehicles	Space for 1 ambulance; double inner and outer doors; heated vestibule	as for (a)	as for (a)
Furniture and equipment	In exposed site conditions a sliding shutter door at one end of the protective canopy may be necessary			
Services	Overhead lighting to canopy and entrance			
ENTRANCE HALL				
Functions	1 To provide facilities for assembly of patients 2 To store wheelchairs and walking aids	Space for 12 patients and 4 staff; storage of 4 wheelchairs 27.75m² (300 sq ft)	Space for 8 patients and 3 staff; storage of 3 wheelchairs 18.5m² (200 sq ft)	Space for 2 patients and 2 staff; storage of 2 wheel-chairs 9.25m² (100 sq ft)
Furniture and equipment	Handrail, bumper for geriatric wheelchairs ± 1m (3 ft) from floor level			
Services	2 13 amp socket outlets			
Relationship to other rooms	Adjoining main entrance and adjacent to cloakroom			
RECEPTION AND RECORDS OFFICE				
Functions	1 To receive visitors 2 To carry out clerical and secretarial work for unit 3 To store current records	2 persons; up to 150 current records 11.25m² (120 sq ft)	1 person; up to 100 current records 11.25m² (120 sq ft)	In smallest units, function likely to be undertaken in office for sister/charge nurse
Furniture and equipment	Desk - single pedestal, chair with arms, chair - stacking, storage for stationery and records			

Services	1 twin 13 amp socket outlet, telephone (may be unit switchboard)			
Relationship to other rooms	Adjoining entrance hall			

PORTER'S ROOM (normally provided in main unit)

PATIENTS' CLOAKS BAY

Functions	1 To allow patients to remove and put on outdoor clothing, with or without assistance 2 To store clothes with reasonable security	9.25m² (100 sq ft)	5.5m² (60 sq ft)	2.75m² (30 sq ft)
Furniture and equipment	Fixed rail hangers for clothes, racks for outdoor footwear, chair with arms (2), board for identity discs			
Services	Nil			
Relationship to other rooms	Adjoining and observed from day activity spaces			

DAY ACTIVITY SPACE

Functions	1 To enable patients to engage in diversional activities and to sit, read, watch television, and listen to radio 2 To enable patients to eat	4 twin 13 amp socket outlets 2.75m² (30 sq ft) per person	1 twin and 2 single 13 amp socket outlets 3.25m² (35 sq ft) per person	2 twin 13 amp socket outlets 3.75m² (40 sq ft) per person
Furniture and equipment	Chairs - geriatric (up to 15% of patients may be in wheelchairs), footstools, room dividers (not exceeding 750 mm (2'6") from floor level), handrails for walking assistance may be required, stain resistant carpeting, storage for recreational materials, record player, television, dining tables, chairs with arms, curtains			
Services	2 socket outlets for television			
Relationship to other rooms	Adjoining entrance hall, observed from nurses' station, ease of access to WCs and all therapy areas, observation of main entrance desirable			

		(a) Major 30-50 places	(b) Intermediate 15-30 places	(c) Minor 10-15 places
WC COMPARTMENT				
Functions	1 Normal use of WC 2 Assisted use with or without sani-chairs or wheelchairs	1 for each 8 places 2.75m² (30 sq ft)	as for (a)	as for (a) but 1 male and 1 female
Furniture and equipment	WC, handrail, toilet-paper holder, hand-rinse basin, paper towel dispenser, disposal bin/bag			
Services	Patients' call system			
Size	WC compartment doors should be wide enough and the compartment large enough for the entry without turning of sani-chairs and wheelchairs and for patients to be assisted. The door should open outwards and be capable of being readily unlocked from the outside should a patient collapse within the compartment			
Relationship to other rooms	Not more than 12.0m (40 ft) from any point in the day hospital			
BATHROOM				
Functions	1 For ambulant patients to bath 2 For patients to bath with assistance	2	1-2	1
Furniture and equipment	Free-standing bath with fitted handrails and hand-shower fitment, bath steps, chair or stool, WC, hooks for clothes and towels, mechanical hoist			
Services	Patients' call system - capable of being operated by patient while in the bath (not ceiling suspended)			
Size	Area - 7.5m² (80 sq ft)			
Relationship to other rooms	Convenient to nurse working rooms			

PATIENTS' REST ROOM				
Functions	To allow patients to rest either after treatment or nursing procedure or if they become indisposed while attending day hospital	1 only	Nil	Nil
Furniture and equipment	Bed, chair with arms, wash-hand basin with wrist-operated taps, shelf at wash-hand basin, mirror, paper towel dispenser, disposal bin/bag, hooks for clothes			
Services	1 twin 13 amp socket outlet, patients' call system			
Size	The room should measure a minimum of 3.0m (10 ft) along the long axis of the bed Area - 10.25m² (110 sq ft)			
Relationship to other rooms	It should be possible to observe the room from the nurses' station			
NURSES' STATION				
Functions	1 Receiving instructions and recording procedures on patients' records 2 Communications centre 3 Point for observation of patients	1 only	1 only	1 only
Furniture and equipment	Wall-mounted writing surface, trolley for patients' records, notice board and peg board			
Services	Overhead light for writing surface			
Size	2.0m² (20 sq ft)			
Relationship to other rooms	Overlooking and near entrance to day activity space, adjacent to nurse working rooms			

		(a) Major 30-50 places	(b) Intermediate 15-30 places	(c) Minor 10-15 places
SISTER/CHARGE NURSE OFFICE				
Functions	1 Administration of day hospital; writing, reading reports and other documents 2 Recording and dictation of correspondence and records 3 Staff consultations 4 Interviewing of relatives	1 only	1 only	1 only
Furniture and equipment	Desk - single pedestal, chairs, bookshelf			
Services	1 twin 13 amp socket outlet, telephone			
Size	The room needs to be large enough for the sister to hold staff discussions Area - 9.25m² (100 sq ft)			
Relationship to other rooms	Adjacent to the nurses' station for easy access to the patients' records			
*PREPARATION ROOM				
Functions	1 Storage for - drugs (including DDA), medicines, lotions, fluids, sterile packs, linen, disposable items, specimen containers, equipment trolleys, other items of equipment 2 Preparation and assembly area for diagnostic and therapeutic procedures	1 at 13.0m² (140 sq ft)	1 at 9.25m² (100 sq ft)	1 at 4.75m² (50 sq ft)
Furniture and equipment	Mobile drug and medicine trolley including DDA etc, lockable cupboards for drugs, lotions, etc, runs of adjustable shelving for a limited amount of linen and underwear, dispensers - with space below for an equipment trolley, sink with high pillar taps, small working surface adjoining sink, paper towel dispenser, disposal bin/bag			

Services	1 twin 13 amp socket outlet			
Size	The shape of the room and the layout of equipment should allow 2 or 3 nurses to work in it at the same time. The room should be lock-fast			
Relationship to other rooms	Adjacent to the day activity spaces and adjoining the disposal room			
DISPOSAL ROOM				
Functions	1 Temporary storage point for all items for disposal or return for reprocessing or replacing, eg pharmacy items. Items for disposal or return include - used and unused materials from opened sterile packs, instruments, needles, syringes, soiled dressings, disposable items (catheters), ampoules, foil, bottles, used linen, papers, wrappings, cartons, flowers, plaster casts	1 at 9.25m² (100 sq ft)	as for (a)	Combined with sluice; 1 at 7.5m² (80 sq ft)
	2 Cleaning of trolleys, etc			
	3 Where laundry facilities do not exist on the site facilities for washing and drying of soiled clothes of patients by mechanical means			
Furniture and equipment	Bins or bags for items awaiting collection for disposal and reprocessing including pharmacy box/basket, holders for bags (eg soiled linen bags), shelving for storage of flower vases and disposable bags, working surface, sink, washable machine/spin dryer			
Services	1 13 amp socket outlet			
Size	The shape of the room and layout of equipment should allow 1-2 nurses to work in it at the same time			
Relationship to other rooms	Adjacent to the day activity spaces and adjoining the preparation room			

		(a) Major 30-50 places	(b) Intermediate 15-30 places	(c) Minor 10-15 places
SLUICE AND TEST ROOM				
Functions	1 Storage of bedpan carriers, disposable bedpans, urinals, specimen containers, sickness bowls	1 only	1 only	Combined with disposal room
	2 Destruction of these items			
	3 Storage of specimens and carrying out of simple tests			
Furniture and equipment	Destructor for disposable items, storage space for disposable items, rack for bedpan carriers, ventilated cupboard for storage of specimens, storage for testing equipment, working surface, sink			
Services	1 13 amp socket outlet			
Size	The size is primarily determined by the functions and not so much by the number of places provided. It needs to be large enough for 1 nurse to be processing bedpans and another carrying out tests Area - 7.5m² (80 sq ft)			
Relationship to other rooms	Adjacent to the day activity spaces and convenient to the disposal room			
PANTRY				
Functions	1 Preparation of occasional beverages	1 only	1 only	1 only
	2 Storage of meals for patients temporarily absent from the unit			
	3 Storage of supplies required for occasional beverages			
	4 Storage of a supply of clean crockery and cutlery unless central arrangements are made			
	5 Occasional washing-up of small amounts of crockery			

Furniture and equipment	Small domestic cooker, electric kettle, small refrigerator, storage for small supply of clean crockery, cutlery, tea, sugar and other other beverages, sink with draining board, working surface, paper towel dispenser, disposal bin/bag			
Services	Socket outlets to suit appliances, unless these are provided with permanently connected supplies, plus 1 additional 13 amp socket outlet			
Size	The size only requires to accommodate 1 person working at a time Area - 4.75m² (50 sq ft)			
Relationship to other rooms	Adjacent to the dining end of the day activity area			
TREATMENT ROOM				
Functions	1 Specialised medical and nursing procedures which cannot be conveniently undertaken elsewhere in unit 2 Occasional plaster work 3 Routine weighing of patients	1 at 16.75m² (180 sq ft)	as for (a) if facilities not readily available in main building	as for (b)
Furniture and equipment	Sink with wrist-operated mixer taps, patient's trolley/couch on wheels, mounting steps, couch stool, dressings trolley, chairs (2), viewing screen, clock, examination lamp (portable), paper towel dispenser, disposal bin/bag, hooks for clothes, trolley for portable suction and oxygen, weighing machine			
Services	2 twin 13 amp socket outlets			
Size	There should be room for up to 3 staff to work around the patient, as well as the equipment permanently in the room			
Relationship to other rooms	Close to preparation and disposal rooms and conveniently accessible from day activity space			

		(a) Major 30-50 places	(b) Intermediate 15-30 places	(c) Minor 10-15 places
WHEELCHAIR BAY				
Functions	Storage of wheelchairs and sani-chairs	6 chairs 4.5m² (48 sq ft)	4 chairs 3.0m² (32 sq ft)	2 chairs 1.5m² (16 sq ft)
Size	To accommodate wheelchairs/sani-chairs parked side by side Area - 0.75m² (8 sq ft) per chair			
Relationship to other rooms	Convenient to entrance and day activity space			
CONSULTING/EXAMINATION ROOM	(this room will only be required if consulting and examination facilities are not readily available)	1 only	1 only	Nil
Functions	1 History taking, interviewing, medical examinations and assessment of new patients, those currently attending and follow-up of discharged patients 2 Recording and dictation of correspondence and records 3 Staff discussions 4 Occasional use to supplement treatment room, eg weighing of patients			
Furniture and equipment	Desk - single pedestal, chair with arms (2), chair - stacking (2), dictating machine, wall-mounted single x-ray viewing box, treatment trolley, wash-hand basin, paper towel dispenser, disposal bin/bag, curtain track and curtain, examination couch, couch step, mirror, coat hooks, wall-mounted sphygmomanometer, portable examination lamp, weighing machine, hinged writing shelf, fitted carpet			
Services	2 twin 13 amp socket outlets, telephone			
Size	The room layout follows that set out in the SHC Information Sheet on "Consulting/Examination Room" Area - 16.75m² (180 sq ft)			

Relationship to other rooms	Adjacent to nurse working rooms			
INTERVIEW ROOM				
Functions	1 Interviewing of patients' relatives and other visitors by visiting health, social work staff, etc 2 Waiting by patients and relatives	1 only	1 only	Nil
Furniture and equipment	Chairs, writing table, fitted carpet			
Services	1 13 amp socket outlet			
Size	The room should be large enough for 4 or 5 people to wait or for 2 or 3 to be interviewed by a member of staff Area - 11.25m² (120 sq ft)			
OCCUPATIONAL THERAPY DEPARTMENT				
LIGHT INDUSTRIAL WORKSHOP				
Functions	For light woodworking and for handicrafts such as cane and leatherwork and weaving	5-8 places; 27.75m² (300 sq ft) - 44.50m² (480 sq ft); these areas may be sub-divided into 2 rooms, one for woodwork and one for other activities	3-6 places; 16.75m² (180 sq ft) - 33.5m² (360 sq ft); larger ones may be sub-divided as in (a)	Depends on local circumstances
Furniture and equipment	Work tables, chairs with and without arms, bench for woodwork, storage for tools, ceiling suspended slings for arm supports, bench stools			
Services	2 twin 13 amp socket outlets			
Size	5.5m² (60 sq ft) per place			
Relationship to other rooms	Adjoining Aids to Daily Living Section			

AIDS TO DAILY LIVING SECTION		(a) Major 30-50 places	(b) Intermediate 15-30 places	(c) Minor 10-15 places
Functions	To re-educate patients in normal daily activities, such as bathing, working in the kitchen, using the WC and getting in and out of bed			
1 BATH AND WC				
Furniture and equipment	Domestic bath, located against wall, bath steps, WC, chair or stool, hooks for clothes and towels, curtain track and curtain	1 only	1 only	Nil
Services	Patients' call system - capable of being operated by patient while in the bath (not ceiling suspended)			
Size	Adequate space is required for patients in wheelchairs to manoeuvre to and from the bath and WC Area - 11.25m² (120 sq ft)			
2 KITCHEN BAY				
Furniture and equipment	Kitchen fitments should be as in an average house with water, gas and electricity services. Some specially designed sinks, cookers, cupboards, etc suitable for patients in wheelchairs, will be necessary	3 places; 16.75m² (180 sq ft)	2 places; 11.25m² (120 sq ft)	Nil use pantry
Services	Socket outlets to suit appliances, unless these are provided with permanently connected supplies, plus 1 additional 13 amp socket outlet			
Size	The bay will normally be used by not more than 3 patients at a time Area - 5.5m² (60 sq ft) per place			
3 BED BAY				
Furniture and equipment	Single bed, adjustable height, easy chair, table	1 only	1 only	Nil

Services	1 twin 13 amp socket outlet			
Size	Area - 9.25m² (100 sq ft)			

OCCUPATIONAL THERAPY OFFICE

Functions	1 Administration of department; writing, reading reports and other documents 2 Staff discussions	1 only	1 only	Nil
Furniture and equipment	Desk - single pedestal, chairs, bookshelves			
Services	1 twin 13 amp socket outlet, telephone			
Size	Area - 9.25m² (100 sq ft)			
Relationship to other rooms	The office should be positioned to facilitate the supervision of the light workshop			

STORES

1 TIMBER ETC

Functions	To store materials used in the light industrial workshop	1 only	1 only	Nil
Furniture and equipment	Shelves, racks and hooks			
Services	1 13 amp socket outlet			
Size	The room should be long and narrow for ease of access to materials Area - 9,25m² (100 sq ft)			
Relationship to other rooms	Adjoining the light industrial workshop			

2 FINISHED ARTICLES		(a) Major 30-50 places	(b) Intermediate 15-30 places	(c) Minor 10-15 places
Functions	To store partly finished and finished articles made by patients	1 only	1 only	Nil
Furniture and equipment	Shelves, racks, hooks and large pigeon hole frames			
Services	Nil			
Size	The room should be wide and shallow for ease of access to items Area - 9.25m² (100 sq ft)			
Relationship to other rooms	Adjoining the light industrial workshop			

PHYSIOTHERAPY DEPARTMENT

ACTIVE TREATMENT AREA

Functions	Exercise of various kinds with groups of patients and individuals	5-8 persons; 21.0m² (225 sq ft) - 33.5m² (360 sq ft)	3-5 persons; 12.5m² (135 sq ft) - 21.0m² (225 sq ft)	3 persons; 12.5m² (135 sq ft)
Furniture and equipment	Wall bars, ceiling suspended slings, walking rails, walking training steps, stools, wall benching, chairs, storage unit for minor items of equipment			
Services	2 13 amp socket outlets			
Size	One wall should be clear of all door and window openings and suitable for fixing wall bars. Window sills should be at least 1.8m (6 ft) above floor level Area - 4.25m² (45 sq ft) per person			
Relationship to other rooms	Adjoining passive treatment area			

PASSIVE TREATMENT AREA

Functions	To undertake all passive treatment within 1 large area in cubicles formed by moveable curtains on tracks	3-5 cubicles	2-3 cubicles	1-2 cubic
Furniture and equipment	Each cubicle (2.25m x 2.5m (7'6" x 8'0")) to allow for a treatment couch, one or two chairs, mobile electrical equipment and a shelf for a lighter equipment. One should be 2.25m x 3.5m or 3.75m (7'6" x 11' or 12') long to allow for medical diathermy apparatus to be used at the head of the treatment couch. One partitioned cubicle may have to be set aside for paraffin wax treatment and plaster splint making and be fitted with a sink, plaster trap and storage cupboard with working surface			
Services	Twin 13 amp socket outlet per cubicle			
Size	A clear 1.8m (6 ft) passageway should remain between the rows of cubicles when the curtains are closed to allow patients in wheelchairs to pass. Where a cubicle is provided for paraffin wax treatment and plaster splint making it should be 16.75m² (180 sq ft)			
Relationship to other rooms	Adjoining active treatment area			

PHYSIOTHERAPY OFFICE

Functions	1 Administration of department; writing, reading reports and other documents 2 Staff discussions	1 only	1 only	Nil
Furniture and equipment	Desk - single pedestal, chairs, bookshelves			
Services	1 13 amp socket outlet, telephone			
Size	Area - 9.25m² (100 sq ft)			
Relationship to other rooms	The office should be adjacent to the active treatment area			

		(a) Major 30-50 places	(b) Intermediate 15-30 places	(c) Minor 10-15 places
DENTAL SURGERY	(this room will only be required if facilities are not readily available and consideration should be given to the possibility of sharing accommodation eg with chiropody or the treatment room)			
Functions	1 Dental inspection 2 Dental treatment	1 only depending on individual circumstances, special consideration to be given to need for a dental laboratory and work room	1 only	Nil
Furniture and equipment	Desk - single pedestal, chair with arms, chair - stacking (2), wall mounted dental x-ray viewing box, dental chair, lamp and unit, mobile dental cabinet, working surface with sink with elbow operated taps and cupboards under, wash-hand basin, paper towel dispenser, disposal bin/bag			
Services	2 twin 13 amp socket outlets, compressed air, telephone			
Size	The room layout should follow the principles set out in Hospital Planning Note No 6, Organisation and Design of Out-Patient Departments Area - 16.75m² (180 sq ft)			
Relationship to other rooms	Near nurse-working rooms			
CHIROPODY ROOM	(this room will only be required if facilities are not readily available and consideration should be given to the possibility of sharing accommodation eg with dental surgery or hairdressing)			
Functions	Chiropody	1 only if alternative facilities and shared accommodation not possible	as for (a)	Nil
Furniture and equipment	Chiropody chair and moveable cabinet, anglepoise light, stool, working surface with cupboards, drawers and knee-hole under, sink with elbow operated taps, paper towel dispenser, disposal bin/bag, foot-bath, stacking chair, impervious flooring			

Services	1 twin 13 amp socket outlet, telephone			
Size	11.25m² (120 sq ft)			
Relationship to other rooms	Near nurse-working rooms			

HAIRDRESSING SALON

Functions	1 Washing, drying and setting of patients' hair 2 Storage of lotions etc	1 only	1 only	Wash in bathroom; dry and set elsewhere
Furniture and equipment	Swivel chair, hairdressing basin with thermostatically controlled hand spray, mirror, storage cupboards and shelves for equipment, lotions, chair with arms, hair dryer on stand			
Services	1 twin and 1 single 13 amp socket outlet			
Size	Area - 9.25m² (100 sq ft)			
Relationship to other rooms	As this room may be used for in-patients its location might be near the main entrance to the day hospital			

EQUIPMENT STORE

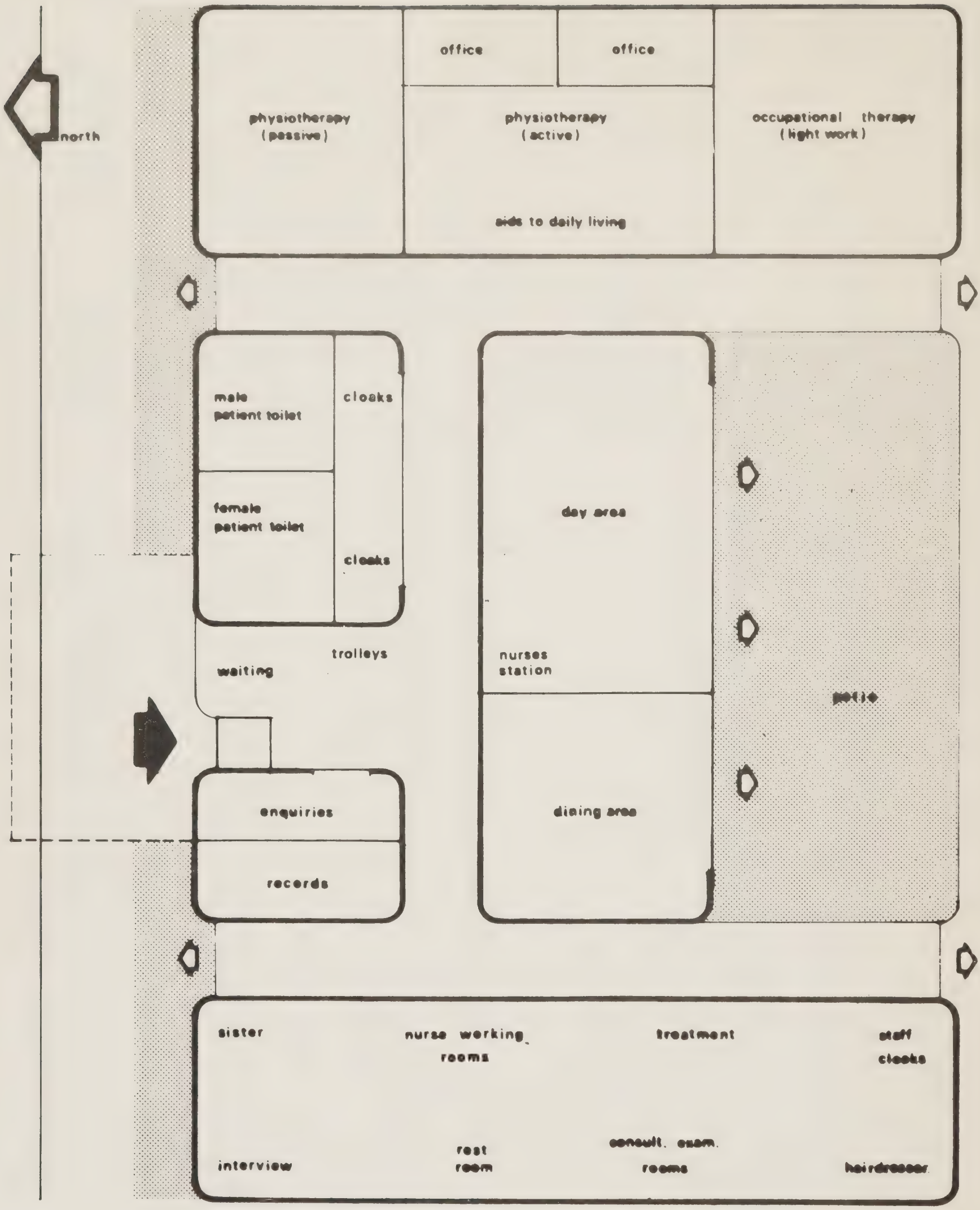
Functions	Storage of bulky equipment and apparatus which is either too large or is not used often enough to justify storage in the working areas, eg walking aids, folding wheelchairs	1 at 3.75m² (40 sq ft)	1 at 2.25m² 25 sq ft)	as for (b)
Furniture and equipment	Racks and hooks with a few shelves			
Size	This room should be wide and shallow with double leaf doors for ease of access to equipment			

		(a) Major 30-50 places	(b) Intermediate 15-30 places	(c) Minor 10-15 places
*DOMESTIC SERVICE ROOM				
Functions	1 Storage of domestic equipment required for cleaning 2 Cleaning and minor servicing of this equipment	1 at 5.5m² (60 sq ft)	1 at 3.75m² (40 sq ft)	as for (b)
Furniture and equipment	Sink with draining board, cleaner's sink, storage for brushes and mops, bins and bags for disposal, duster rack, suction sweeper, mechanical polisher, shelving for cleaning materials, paper towel dispenser, cleaner's trolley			
Services	1 single 13 amp socket outlet			
Size	The room should be square as long narrow rooms are unsuitable. As mops and brushes may have to be dried this room should be well ventilated. Adjacent to nursing rooms			
	* See principles as outlined in Scottish Hospital Centre Information Sheet "Domestic Service Room"			
STAFF CLOAKROOMS				
Functions	1 Cloakroom for women 2 Cloakroom for men (changing accommodation for non-resident staff is assumed to be provided centrally and sub-unit cloakrooms need provide only for cloaks and personal items, ie wallets and purses)	For females 4.50m² (50 sq ft) For males 2.25m² (25 sq ft)	as for (a)	2 at 2.25m² (50 sq ft)
Furniture and equipment	Individual lockers (approx 0.07m² (0.8 sq ft)) for personal items, hooks for clothes, wash-hand basins, shelves at wash-hand basins, mirrors, paper towel dispensers, disposal bins/bags			

STAFF WCs

Functions	1 WCs for women 2 WCs for men	For females 2 at 2.0m² (20 sq ft) For males 1 at 2.0m² (20 sq ft)	as for (a)	2 at (20 s
Furniture and equipment	WC, toilet paper holder, hand-rinse basin, paper towel dispenser, disposal bin/bag			
Relationship to other rooms	Opening off staff cloakrooms			

APPENDIX I



1973 SUGGESTED DIAGRAMMATIC LAYOUT

APPENDIX II

DESCRIPTION OF EIGHT DAY HOSPITALS SURVEYED

DAY HOSPITAL 1

This purpose-built single storey geriatric unit with assessment and long-stay beds and including a day hospital, was completed in 1972. The day hospital adjoins the administrative, out-patient and x-ray departments of the main unit and has access to the dental, chiropody and hair dressing sections. The day and dining rooms have a south exposure and both overlook an interior garden. Construction was in load bearing brickwork, clad externally in facing brick. Internal partitions are of plastered brick. Doors, frames etc are of hardwood. Shower and toilet area floors are tiled: the remainder of the flooring, except the carpeted areas, are of PVC sheeting. Access to services is obtained by demountable suspended ceiling tiles.

Relevant data

The day hospital, designed for 50 places but currently staffed for 40, has 160 patients under treatment per week giving a ratio of 4 patients to 1 place. An urban population of 220,000 was served giving ratios of 1 day place to 5,500 of the population and 1 day patient to 1,375 of the population.

Design comment

1 The entrance and ambulance unloading area had a porch cover and was further protected by means of a manually operated galvanised steel horizontal shutter some 3.3m (11'0") in length and approximately 3.0m (10'0") in height

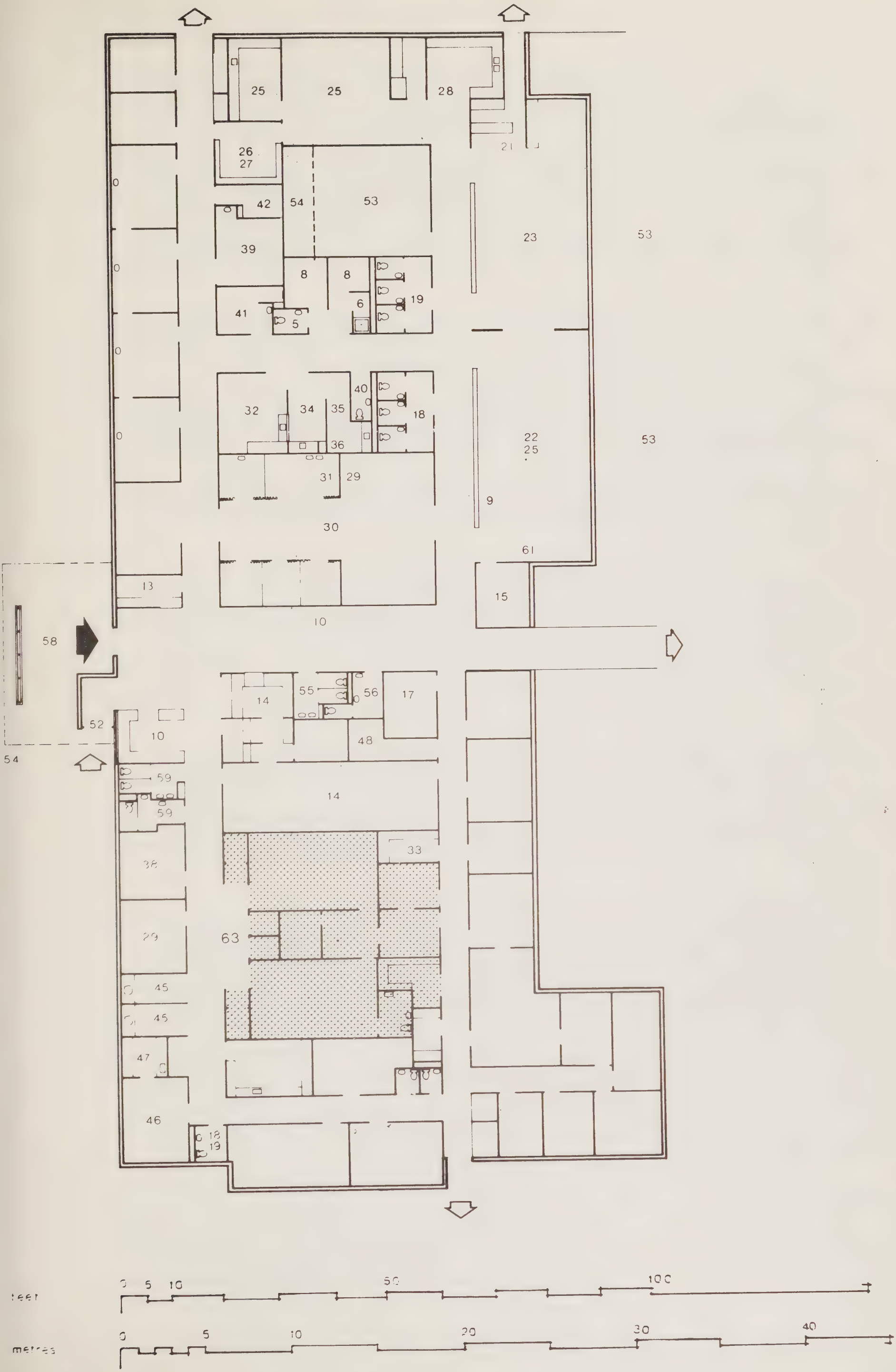
2 The main entrance hall was entered by one set of automatically operated sliding doors. Because of the time lag in operation and lack of a vestibule the combined entrance hall, waiting area and open office for the clerkess/telephone operator, were both cold and draughty

3 The main entrance to the day room was at some distance, 24.5m (80 ft), from the entrance door

4 The area of the day and dining spaces at 157.0m^2 (1690 sq ft), 3.2m^2 (34 sq ft) per person, was excessive: 139.4m^2 (1500 sq ft) for day activity spaces would have been a more suitable figure

5 An impression of spaciousness was maintained by use of an open timber screen between the 2.4m (8'0") wide spine corridor and the day/dining rooms

6 WC compartments at 1.4m (4'9") wide x 1.5m (5'0") deep were too small for assisted toileting. They were further restricted by positioning of grab rails. Because of this, compartment doors had been subsequently converted to open in and out and did not lock. The sliding outer door to the toilet areas and the inability to take wheelchairs within the compartments reduced privacy from the adjoining day/dining areas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7 The clinette was too small to accommodate a nurse with a patient on a wheelchair; consequently patient transfer was carried out from the corridor

8 Only one of the two bathrooms could accommodate a mechanical lifting aid and a wheelchair. Both rooms lacked laying surfaces. The fitting of sliding doors to both bathrooms in relation to the adjoining 'short cut' used by hospital staff reduced privacy during bathing. Mobile screens had to be used here and outside the adjoining WC

9 The shower cubicle shape prevented assisted bathing and was being used as a patient clothes drying area in conjunction with a domestic washing machine and spin dryer in the disposal room

10 The distance, 7.6m (25'0"), between the WC compartment adjoining the two bathrooms and the 'dirty' treatment room when used for enemata was excessive

11 Storage provision for occupational therapy was reduced by approximately 1/3 because the working room was occasionally used for general circulation

12 The patio adjoining occupational therapy and dining areas required planting to soften the existing 'hard' landscape. On calm sunny days difficulty had arisen in achieving enough air movement within the patio to ensure an acceptable air temperature.

General

Criteria for admission were need for assessment, diagnostic or therapeutic purposes, rehabilitation, general support and social reasons. Approximately 66% of the patients were admitted from the geriatric consultative clinics, the remainder coming from the group assessment unit either before or after their discharge from the in-patient area. Incontinence of bowel or bladder and mild confusion were no bar to admission.

As part of assessment and follow up the homes of all patients were visited by health visitors attached to the unit. Occasionally homes were visited by medical and other members of staff. Review depended upon the condition of the patient. Case conferences were held weekly and medical teaching was undertaken. The active policy of discharge involved a gradual reduction in frequency of attendance followed by periodic review. Alternatively the patient might be admitted to an in-patient unit. A tenuous link existed with one local authority day centre. The two Medical Social Works (MSWs) attached to the geriatric service maintained contact with the local authority department of social work. Records were exclusive to the geriatric service and not incorporated in a group system.

Activities

Comprehensive diagnostic and therapeutic medical activities were undertaken in the consultative suite and in the "clean" treatment room.

Combined clinics with a psychiatrist were held weekly.

Nursing activities involved the bathing of patients, dressing small wounds and ulcers, the occasional removal of sutures, weighing patients, the administration of medicines, enemata and suppositories, collection of urine and stool samples, washing soiled clothing, and general co-operation with the remedial therapists.

Physiotherapy consisted of individual treatments and therapy to small groups of patients.

Occupational therapy covered recreational and diversional activities, light craft work, woodwork and aids to daily living.

A chiropodist and a dental surgeon attended for one session per week. Instruction of relatives was undertaken by medical staff in the consultative suite and by nursing staff and the remedial therapists in the day hospital. Hairdressing of female patients was performed in a salon. Voluntary workers acted as the "patient's friend" in the consultative suite. Catering was provided from the main kitchen of the hospital, although hot drinks were prepared in the servery.

Pattern of activity

About 09.30 patients began to arrive in ambulances. Assistance was provided by drivers, porters and nurses. Outdoor clothes were removed as the patients entered the day room and were securely stored in a room opening off this area. Clothes were not labelled but were grouped, according to the type of transport used by the patient. After entering the day room, the patients were given a hot drink.

From 10.00, while some patients were still arriving, some of those who had come earlier moved to the physiotherapy and occupational therapy departments for treatment. Earlier these departments had been used by patients from the in-patient area. Patients were in these departments in groups of 6-8 until mid-day. The remainder were in groups in the day room, engaged in social and recreational activities.

The general organisation of patients' activities was the responsibility of the sister in charge of the day hospital. Most of the basic nursing care and treatment was previously arranged and it was possible to organise a programme of work. During the day 19 patients were bathed. Two nurses were required for 14 patients, 7 of whom required a mechanical hoist, and 1 nurse for 5 patients. One patient used the shower.

The main areas used by nursing staff were:-

a preparation room
b disposal room
c sluice
d WCs
e clinette
f "dressing room" and "dirty" treatment room
g 2 bathrooms
h shower room

Lunch commenced about 12.00 and was completed about 12.45. The patients then rested in the day room. In the afternoon the activities in the nursing area and in the remedial departments decreased significantly, social and recreational activities predominating in the day area. Tea was served to the patients about 15.00 after which they were assisted to prepare for their journey home which commenced about 15.30.

Comments by the study team are given as they affect the unit's four main users - the patients, the remedial therapists, the nurses and the doctors.

For the patient

1 Slight delays occurred on arrival and on departure at the entrance where some of the patients became cold while waiting

2 WCs for patients waiting near the main entrance would have been an additional amenity

3 The use of individual name tags for outdoor clothes would have been an advantage

4 Although a domestic washing machine had been provided for patients' clothes there were no drying facilities, apart from a curtain rail in a shower

5 Sharp corners of tables in the dining space had caused minor injuries to patients

6 Double swing WC doors were a hazard for the patients: these doors were without "engaged" indicators

7 Lack of an internal patient call system from the WCs was a disadvantage

8 A sliding door to the main WC area did not afford privacy.

For the remedial therapists

a <u>General</u>

The physical separation of the physiotherapy department from the OT department by the nursing area led to difficulties as many problems should be dealt with on a joint basis.

b <u>Physiotherapy department</u>

1 Although well equipped, if the decision had been taken to have beds for treatment instead of plinths it would be desirable to have at least one adjustable height bed

2 Wall mounted cupboards with side-opening doors and free floor space underneath had given the staff minor head injuries - in such cases doors should slide

3 Insufficient writing space for records had been provided

4 Plaster work was undertaken but no plaster traps had been provided for the sink

5 More storage for equipment such as walking aids, sticks, etc was required within the department

6 Location of the superintendent physiotherapist's office in the administrative area of the main hospital was a disadvantage: it would have been better to have had it adjacent to the department.

c Occupational therapy department

1 The Aids to Daily Living (ADL) section and the woodworking area were both too small for the numbers of patients requiring to use them at any one time

2 More specialised storage was required for raw materials, work in progress and finished articles.

3 An office adjacent to the working areas would have been an advantage.

For the nurse

1 A lockable medicine trolley with a DDA cabinet and an "anchor" point would be sufficient, compared with the fixed unit provided: in this day hospital drugs were prescribed by the consultant geriatricians

2 No storage unit was provided in the preparation room for spare clothing for patients

3 Too many activities were being undertaken in the preparation room, including office functions: the "dirty" treatment room was under-utilised

4 The provision of both a sink and a wash-hand basin in the sluice was unnecessary

5 The practice of this unit was to use the disposal room for washing personal clothing for patients.

For the doctor

1 The close association of the consultative suite to the day hospital and its relatively high utilisation facilitated the review of patients

2 Although the major x-ray unit and supporting accommodation adjacent to the day hospital served the geriatric unit including the day hospital, the department was to be significantly under-utilised and it was debatable whether the provision was justifiable.

For the dentist

Dental facilities provided for the geriatric unit including the day hospital were to be used relatively infrequently, approximately 4 sessions a week.

Other comment

1 The small "pharmacy" had not been used because of staffing difficulties

2 It was not clear why a separate record system for the area geriatric service was being maintained

3 Closer functional links with day centres were necessary.

DAY HOSPITAL 2

This purpose-built day hospital formed at ground floor level part of a large district geriatric unit with assessment and long-stay beds. Construction was completed in late 1971. The main building is constructed in reinforced concrete frame with concrete floors. Infill panels are cavity brick rendered with continuous bands of aluminium windows. Internal partitions are metal stud and plasterboard with hardwood doors and door frames. Outwith carpeted areas, the floor coverings are stiletto resistant linoleum or terrazzo in toilet and service areas. Access to services is obtained via demountable ceiling tiles of an 'exposed grid' type.

Relevant data

The day hospital has 40 places and at the time of the survey 100 patients were under treatment giving a ratio of 2.5 patients per place. An urban area population of 225,000 was served giving ratios of 1 day place to 5,600 of the population and 1 day patient to 2,250 of the population.

Design comment

1 The linear plan adopted because of site configuration resulted in travel distance within the unit being lengthy, eg day activity area to occupational therapy department was 61.0m (200'0")

2 Minimal weather protection was provided at the entrance door for the patients when alighting from transport. The canopy, approximately 2.0m (6'6") wide, was too high to prove effective

3 Travel distance from the main entrance door of the geriatric unit to the space for cloaks in the main corridor of the day hospital was some 30.5m (100'0")

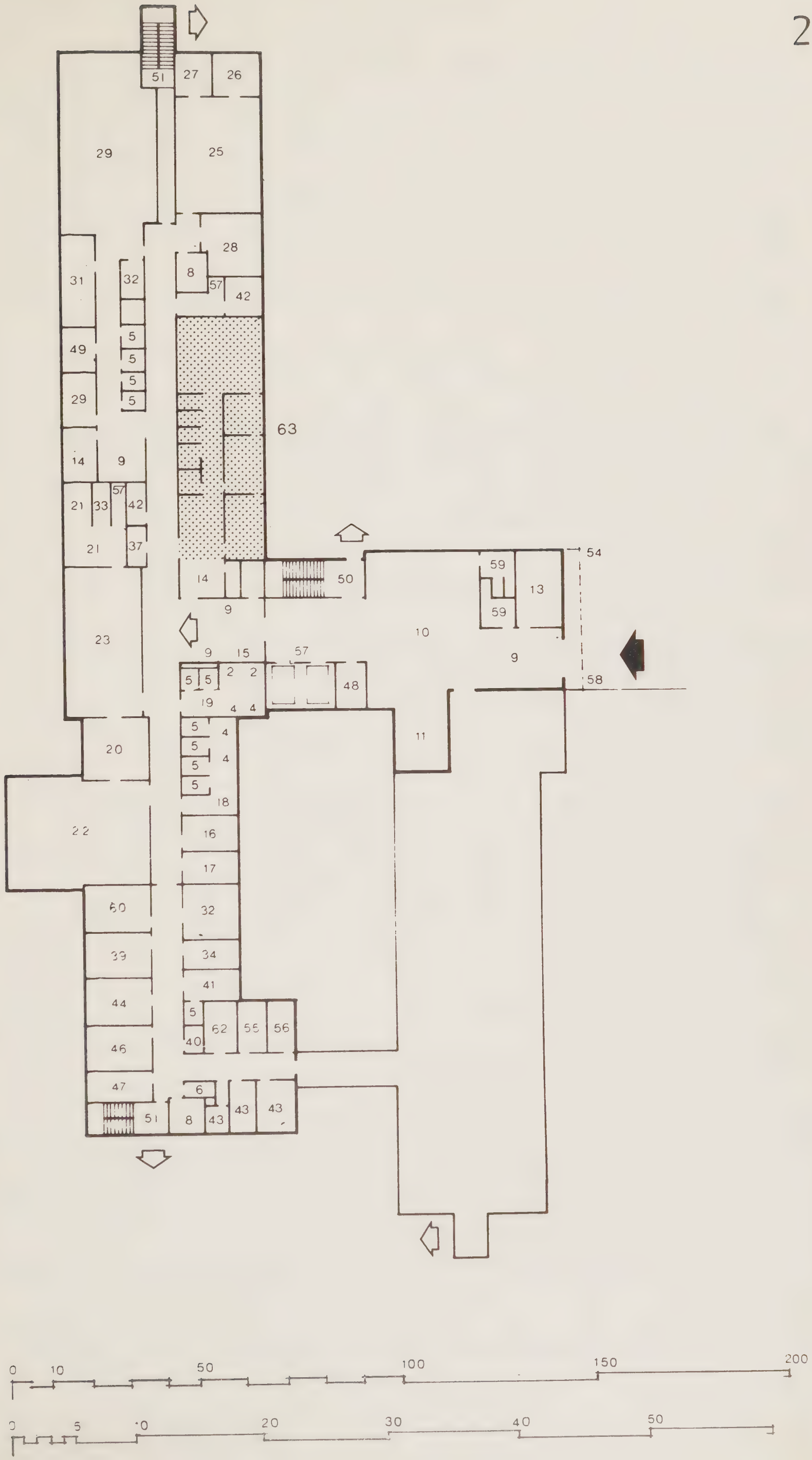
4 A crossing of patient traffic routes with ensuing confusion occurred when part of the day space was used as a waiting area for out-patient clinics at the same time as patients proceeded to and from the main day spaces and other parts of the day hospital

5 The area of the day activity spaces (dayroom, dining room and coffee lounge) at 175.6m^2 (1890 sq ft) or 4.4m^2 (47 sq ft) per person was excessive. 111.5m^2 (1200 sq ft) would have been a more suitable figure

6 The warm domestic atmosphere of the otherwise large scaled rooms, ie, lounge, coffee lounge and dining room had been achieved by the use of high quality fitted carpeting throughout

7 The 2.4m (8'0") wide main corridor ensured ease of patient movement

8 WC compartments 1.5m (5'0") wide by 1.7m (5'6") deep, containing a hand-rinse basin, were difficult to use by the 'assisted' patient, partly because of overall area but principally because of relation-



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ship of WC bowl and hand-rinse basin to the inward opening cubicle door

9 The shower shape with a width of 1.1m (3'6") made assisted showering extremely difficult

10 Folding doors fitted with lightweight metal sliding gear had been fitted to both clinette and shower and had failed under infrequent usage

11 The finishes throughout the building generally resulted in a robust and attractive building.

General

The criteria for admission were medical need for diagnostic or therapeutic purposes, assessment, rehabilitation, general support and trial 'ischarge. Social factors were not normally considered a reason for admission. A consultative out-patient clinic with two consulting rooms in part of the day hospital was used for the review of patients attending the day hospital and for nursing procedures. About 80% of the day patients were seen there: the remainder came from the in-patient area in preparation for their discharge home.

Incontinence of urine was no bar. Some patients who were incontinent at home became continent after attending the unit for a short time. If there was no improvement they were treated on an in-patient basis. There was no difficulty about cleaning soiled garments as a dry cleaning plant was on the same site. Incontinence of bowel was considered a bar to entry to the day hospital.

The homes of all patients were not visited as only two district nurses were attached to the unit on a part-time basis. Two medical social workers attached to the geriatric service spent part of their time in the day hospital, making contact with the local authority department of social work when necessary. Records were maintained on a group basis but records of patients currently under treatment were held within the day hospital.

Activities

Diagnostic and therapeutic medical activities were undertaken in the two consulting rooms, the enema room and the recovery room.

Nursing activities involved the bathing of patients, dressing small wounds and ulcers, the occasional giving of enemata, supervision of the administration of medicines prescribed by general practitioners and the occasional giving of injections. Nurses also collected and tested urine specimens and assisted in out-patient work. Each nurse was made responsible for a group of six or seven patients, nursing treatment being co-ordinated with other treatments according to a time-table arranged by the secretary of the day hospital. They co-operated with the remedial therapists.

Occupational therapy covered recreational and diversional activities and

light craft work. The ADL section contained a kitchen for intensive instruction of individual patients and a bathroom for actual bathing of patients, instruction of patients and training to dress.

Physiotherapy consisted of individual treatments in a well-equipped department. Patients requiring chiropody were treated in the wards. A well-equipped dental surgery, dental laboratory and dental workshop were used for approximately four sessions per week but mainly for patients from the in-patient area. Speech therapy was undertaken in a well-equipped suite for 4 sessions per week. Instruction of relatives was undertaken on occasions by nursing staff and the remedial therapists.

Hairdressing of female patients was performed in a salon by trainee hairdressers from a local further education college and also nursing staff. Catering was provided from the main kitchen of the hospital although hot drinks and light refreshments were prepared in the servery of the dining area. A dietitian spent a short time in the day hospital each day. The services of an optician could be obtained readily.

Pattern of activity

Patients began to arrive at the main entrance to the hospital about 10.00, and were assisted from there, as necessary, by drivers, porters and nurses. Wheelchairs were stored 30.5m (100 ft) from the unloading point. Outdoor clothes were removed in the circulation space and stored on a simple hat and coat stand. Clothes were labelled but little security was provided. Patients then entered the day room where they were provided with a morning drink.

Occupational therapy, speech therapy and nursing treatments commenced about 10.30 in accordance with a pre-determined programme. The remedial therapists had been employed earlier in the morning in the ward areas. Physiotherapy commenced about 11.15, the physiotherapists previously working in the wards. Lunch, served at 12.30 and completed by approximately 13.00, was followed by a rest period. In the afternoon, therapy and treatments started in the morning were continued but on a diminishing scale of intensity. Out-patient consultations took place at this time, increasing the traffic in part of the circulation area of the day hospital, in particular in the examination and consulting room areas. Tea was served at 15.30 and at approximately 15.45 patients were assisted to prepare for their return journey home which commenced at approximately 16.00.

Throughout the day simple social and recreational activities took place in the day room with patients in small groups. The main occupational therapy (OT) department never contained more than 6 or 7 patients at one time engaged in simple craft activities but one or two patients were being intensively treated in the ADL section in the morning. The physiotherapy department never had more than approximately 4 to 5 patients at any one time.

The main nursing areas consisted of:-

a preparation room
b sluice

c WCs
d enema room
e recovery room
f bath and shower room in the nursing area

The general organisation of patients' activity was the responsibility of the sister in charge of the day hospital, assisted by the secretary.

Comments by the study team are given as they affect the unit's four main users - the patients, the remedial therapists, the nurses and the doctors.

For the patient

1 Some inconvenience occurred because of the distance from the unloading point to the area for the storage of wheelchairs; patients had to wait at the main entrance for wheelchairs; this area was uncarpeted and draughty

2 Although clothes were tagged, storing them in an open unsupervised circulation area had on occasions led to items going missing

3 There was no external area for patients in good weather

4 The large and bulky geriatric chairs in the day area did not permit them to be positioned in small groups - a greater variety of type would have been an advantage

5 Heavy fire doors in the main corridors created difficulties for handicapped patients.

For the remedial therapists

a General

The physiotherapy and OT departments were adjacent to each other but from the dining and day areas patients had to walk or be transported 39.6m (130 ft) to reach these departments - a rather long distance. The intervening space was occupied by the hospital x-ray department for the unit and sub-waiting and reception facilities for the remedial therapy and radiology, all of which were substantially under-used.

b Physiotherapy department

1 Although well equipped it would have been an advantage to have had overhead grids rather than the wooden overhead supports which had been provided

2 There seemed to be over-provision of space for wax treatments as the footbath was not used

3 Each cubicle had a fixed infra-red lamp set on the right hand wall at the head end of the couch. Mobile lamps would have led to greater flexibility of use

4 No office had been provided for the physiotherapist. It would have been an advantage to have one overlooking the treatment area.

5 No area had been set aside or equipment provided for plaster work

6 A shortage of physiotherapists limited the full utilisation of this department.

c Occupational therapy department

1 This department only allowed for craft work and light industrial activity

2 Storage for materials and finished products was good within the department. Bulk storage for materials was in the main unit

3 The absence of an overhead grid was not a disadvantage as mobile arm supports were used

4 The shower in the ADL area was not used as it was unpopular with patients

5 The electric cooker in the kitchen, with controls above and to the rear of the hot plates, was dangerous for disabled persons. Otherwise the kitchen was well equipped and used moderately intensively by the occupational therapists and the dietitian

6 The lack of a bedroom or access to a bed on the day hospital floor limited comprehensive instruction in daily living activities

7 The occupational therapist had a separate office some distance from the main working area. It would have been an advantage to have had the office with a glazed panel overlooking the working area.

For the nurse

1 The preparation room was well equipped but contained a disposal sack for used material: as such the room was being misused

2 The "sluice" adjacent to the preparation room could have been used for disposal purposes

3 A small narrow room with a WC opening off, originally provided for the administration of enemata, was being used as a dressing room when a consulting room was not available. Plaster of Paris splints were prepared and applied in this room; no plaster trap had been provided

4 The original design had not included a rest room but an office had been converted for this purpose

5 The bathroom contained a "boxed in" bath at normal domestic height which made it difficult for assisted bathing: the "boxing in" precluded the use of a mechanical hoist. No laying surface had been provided

6 The design of WCs for patients limited the amount of nursing assistance which could be given to patients. The clinette and associated laboratory were not used.

For the doctor

1 The consultative suite immediately adjacent to the day hospital simplified the review of patients and enabled the positive discharge and review policy to be maintained

2 The radio-diagnostic department was significantly under-used - approximately three patients from the day hospital were referred to it each week

3 Closer functional links with day centres would be desirable: it was stated that a day hospital of 40 places should have close functional links with approximately five day centres, each serving populations of up to 30,000.

For the dentist

The very extensive dental facilities were only used for approximately 40% of the working week.

DAY HOSPITAL 3

Previously a sitting room with an adjoining single WC compartment in a former nurses' home of a medium size hospital which included 66 of the 110 assessment beds for the area: to this accommodation had been added one similar WC compartment gained when the adjoining occupational therapy department for the main hospital had been erected in 1970.

Relevant data

The day hospital has 15 places and with a ratio of 1.8 patients to one place was providing a service for 27 patients from a semi-urban population of 90,000. This gave ratios of one day place to 6,000 of the population and one day patient to 3,300 of the population.

Design comment

1 Lack of shelter at the exterior entrance door led to patient discomfort when alighting from vehicles

2 The arrival of patient transport could not readily be observed

3 Intensive multi-use of the very small day activity space of 46.5m² (500 sq ft) created problems

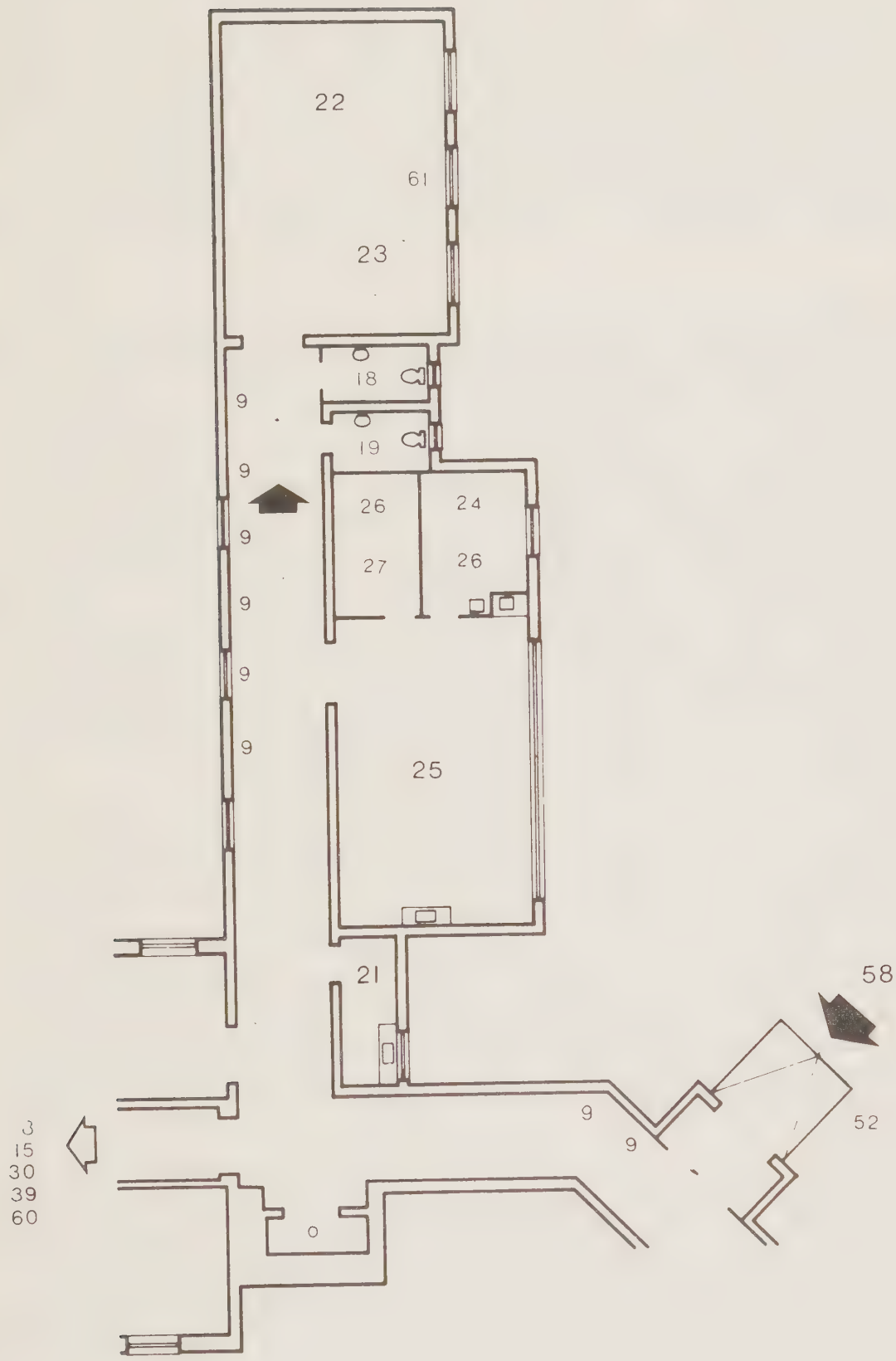
4 WC compartments were too narrow for use by assisted patients - 1.3m (4'3")

5 The limited amount of space within the day hospital meant that storage was located at some distance outwith the area. Patients and staff had to travel 54.9m (180'0") to the physiotherapy department.

General

Criteria for admission were suitability for treatment by the remedial therapists, social factors, the need to undertake certain simple diagnostic procedures and nursing activities. Some patients were discharged in-patients but "pre-discharge" in-patients were not dealt with. The remainder had been seen at a geriatric out-patient clinic or occasionally as the result of a domiciliary visit. The out-patient department, used by other specialties, was in the same building but at the other end of a corridor 61.0m (200 ft) long and separated from the day hospital by the main physiotherapy department and other accommodation. Incontinence of urine was not a bar to admission to the day hospital provided it was mild and improved after admission. Patients who were incontinent of bowel were not admitted.

Review of discharged patients was on an ad hoc basis depending on the condition of the patient as assessed by the general practitioner or by the two full-time health visitors provided by one local authority. An active policy of discharge and follow-up was standard for all patients. Case conferences were held monthly and involved all those working in the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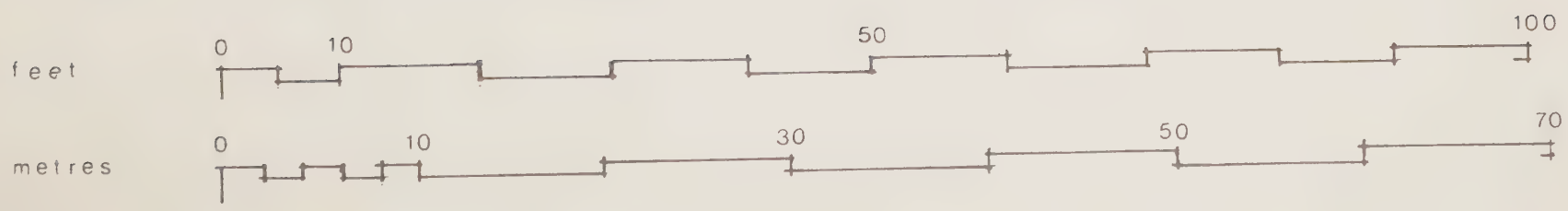
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day hospital, including representatives of the ambulance service. The area geriatric service had two medical social workers who spent a limited amount of time dealing with problems arising from day patients, and as required contacted the local departments of social work. The records of the geriatric day patients were not incorporated in the group record system.

Activities

The lack of space for diagnostic activities meant that, when necessary, patients had to be transferred to the out-patient department at the other end of the same building. Therapeutic medical activities in the day hospital were limited to the administration of drugs. Physical therapeutic measures were limited to those which could be provided in the occupational therapy and physiotherapy departments which were located in the same building but also served the main hospital. Remedial therapists were not exclusively allocated for work with day patients.

Nursing activities included escorting the patients to and from their homes. Within the hospital their work mainly consisted of toileting, bathing, giving medicines and treatments and assisting with feeding. Treatments included dressings, injections, eye-bathing, changing catheters and giving suppositories on occasions. The sister, who was also in charge of the out-patient department, with the assistance of a secretary generally controlled the attendance. A chiropodist and a hairdresser provided a service for the hospital as a whole. The former attended the day hospital approximately once weekly, seeing 3 day patients, and the latter approximately three times weekly, seeing two or three patients on each occasion. Soiled clothing was washed by the nurses and taken home by the patient in a polythene bag. The nurses also supervised simple social and diversional activities.

Occupational therapy for all hospital patients was undertaken in a purpose-built timber extension adjacent to the day room of the day hospital. Normally 6 day patients attended occupational therapy in the afternoons for recreation and simple diversional activities. A further 6 attended for light industrial activities such as basket making. A limited amount of use was made of simple ADL equipment in the occupational therapy department: these were confined to "kitchen" activities.

One to three patients from the day hospital attended the physiotherapy department at times convenient to the physiotherapists. Virtually no instruction of relatives was undertaken in the day hospital but by appointment they could see the clinicians in the out-patient department. Catering was provided from the main hospital, although hot drinks were prepared in the small kitchen with limited facilities, located off the access corridor to the day hospital.

Pattern of activity

Patients arrived about 10.00 and were taken to the day room where their outdoor clothes were removed and placed in a "cleaners cupboard" in the main corridor of the building, some distance from the day room. The

patients were then given a hot drink and any necessary oral medicine, and thereafter nursing treatments and bathing, commenced. During the day of the visit one patient was incontinent and required bathing (the numbers varying from one to three a day). One or two patients went to the physiotherapy department. At 11.30 the day room was prepared for the mid-day meal which was completed by 12.30. The rest period commenced at 13.00 and at 14.00 tea was given to the patients. Some patients then went to occupational therapy and three times a week group physiotherapy was undertaken in the day room. Preparation of the patients for the return journey commenced about 15.00, the ambulances arriving at 15.15.

The work of all staff was complicated by the cramped working conditions and dispersed and limited supporting facilities. The fact that the day room served as a dining room, nurse's station and an area for diversional therapy was a great disadvantage to patients and staff. It was overcrowded with nursing equipment, records and medicine trolleys, and chairs and tables for the patients.

The areas used by nursing staff were of indifferent quality. The corridor was used for storage of wheelchairs, geriatric chairs, oxygen cylinder etc. Two WCs were available for patients but those in wheelchairs could not be taken into them and the door shut - a mobile screen was used in such circumstances. These WCs were also used for disposal storage. A bathroom of 8.6m^2 (93 sq ft) with a free-standing bath provided adequate space for bathing patients, but as the unit lacked treatment or preparation rooms this had to be used for preparation and disposal purposes, for dressings and treatments, and for chiropody and hairdressing. The linen store was in the out-patient department in the main hospital. A trolley was stocked each morning with the anticipated requirements of the day hospital and kept in the bathroom.

Comments by the study team are given as they affect the unit's four main users - the patients, the remedial therapists, the nurses and the doctors.

For the patient

1 Reception facilities and the accommodation left much to be desired

2 Storage of outdoor garments in a "cleaners cupboard" was quite unsuitable

3 The size of the WC compartment and the fact that it was used for storage purposes made it difficult for patients to use the WCs on their own, and very difficult to be used as an "assisted" WC

4 The size of the combined day and dining area, 44.6m^2 (480 sq ft) was much too small, particularly because it was used for a number of other functions

5 There were no special facilities for dealing with clothes which had been soiled

6 The lack of a garden was a disadvantage in the summer months.

For the remedial therapists

a General

The demands made on these departments by the other specialties in the hospital did not permit them to devote sufficient time or as much time as they would have wished to day patients

b Physiotherapy department

Separation from the OT department was a distinct disadvantage

c Occupational therapy department

The lack of a fully equipped ADL area ie bath and WC and kitchen and bed bays, was a distinct disadvantage.

For the nurse

Little need be added to what has been said before apart from stressing that the lack of a separate dining room and nurse working rooms made for extremely difficult working conditions for the nursing staff.

For the doctor

1 The medical staff had no facilities in the day hospital

2 Closer functional links with day centres were also required.

DAY HOSPITAL 4

Previously a stone built potting shed of a former poorhouse: a timber extension had been added in 1968. Irregularities of site configuration resulted in three variations in floor level; movement within the premises was severely restricted by the necessity for access ramps and irregularities of plan shape.

Relevant data

The group assessment unit was nearby in the same building. The day hospital had 15 places and at the time of the survey 32 patients were under treatment giving a ratio of two patients to one place; in a population of 182,000 in an urban area this gave ratios of one day place to 12,100 of the population and one day patient to 5,700 of the population.

Design comment

1 The absence of a covered shelter at the main entrance resulted in lack of protection for patients alighting from vehicles

2 Lack of equipment storage space resulted in the utilisation of the patient WC for this purpose

3 The position of the WC pedestal close to the wall in the WC compartment for patients resulted in great difficulty when a patient required assistance

4 The inadequate provision of WCs resulted in the adjoining staff WC being used by patients

5 Movement within the unit was extremely difficult because of narrow access corridors and links

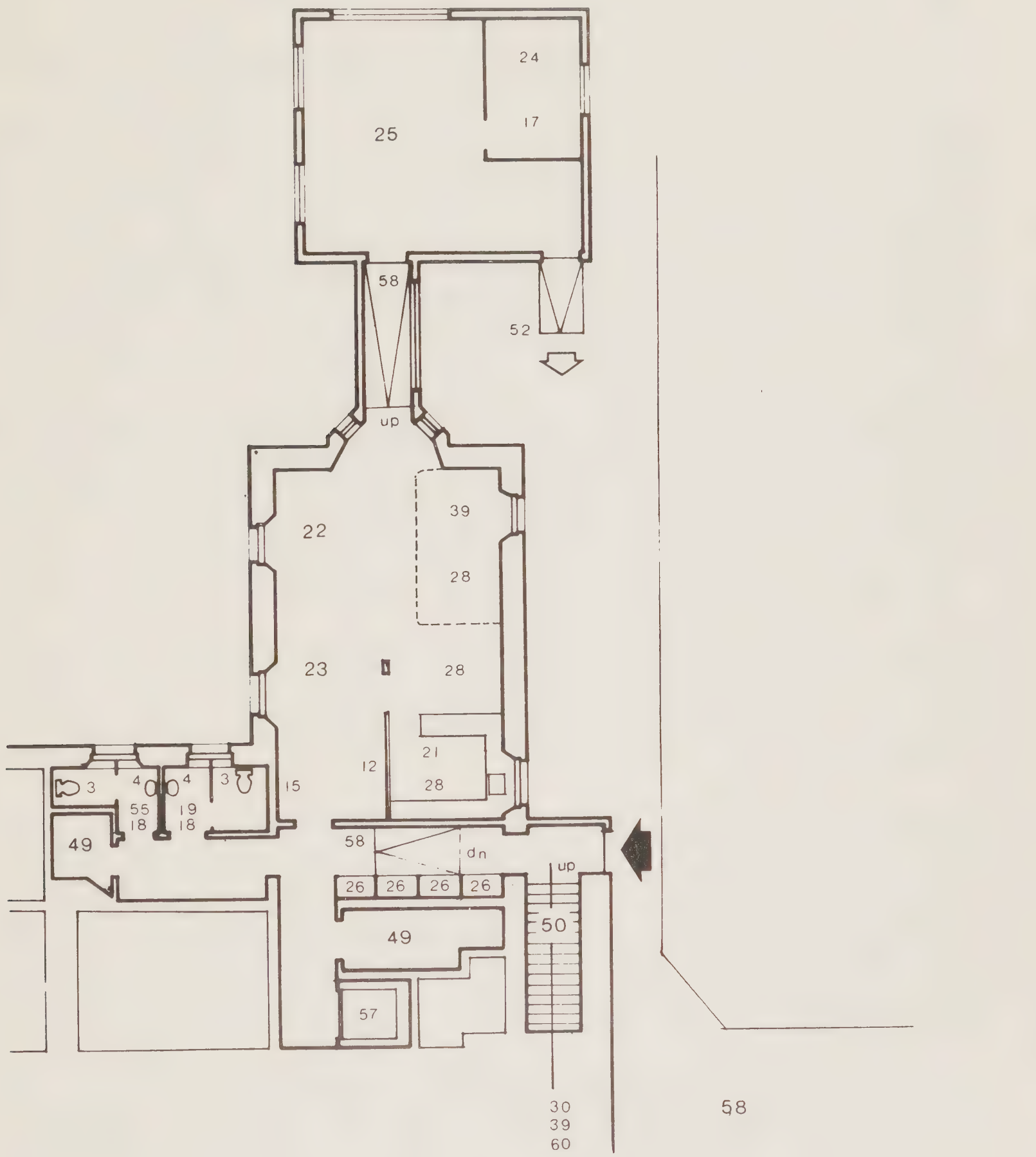
6 Shortage of accommodation for reception, dining, occupational therapy and treatment and assessment, resulted in difficult working conditions

7 A general purpose examination/treatment room situated one floor above in the main geriatric unit was inconvenient to use

8 The fact that facilities for physiotherapy were located in the main geriatric unit 2 floors above the day hospital produced difficulties for the staff in moving patients.

General

Staffing shortages limited the operation of the unit to four sessions a week from 09.00 to 14.00. In the afternoons the accommodation was used for occupational therapy for psychiatric patients and for speech therapy for out-patients and in-patients.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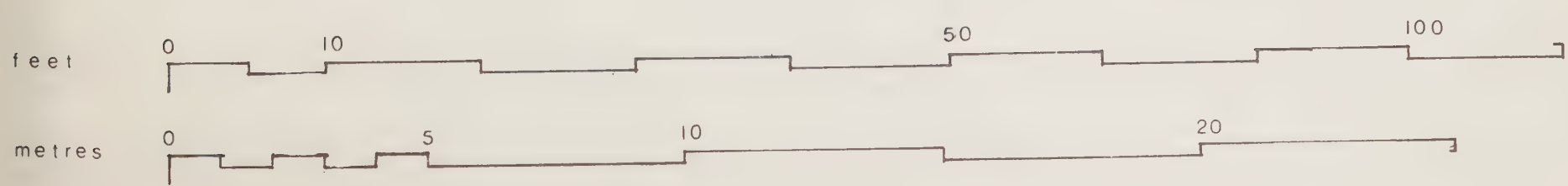
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Criteria for admission were need for diagnostic or therapeutic purposes and extended assessment which could not be undertaken on an out-patient basis. Patients who had been discharged from the in-patient accommodation or seen previously as out-patients were admitted if thought suitable to avoid admission and to provide supportive therapy. On rare occasions patients were admitted for social reasons. Incontinence of bladder was not considered a bar but if it continued after admission the patient was transferred to an in-patient unit.

The homes of all new patients were not visited routinely but contact with the local authority department of social work was good. This was fostered by attendance of the deputy director of social work at the hospital's weekly case conference which was also attended by medical staff, nurses, remedial therapists and the medical social worker. Each individual patient was reviewed in detail at monthly intervals or more frequently on an ad hoc basis depending on circumstances. Discharge and follow-up followed no set pattern but depended on the circumstances of the individual patient. Discharged patients were reviewed at a consultative out-patient clinic at monthly intervals for varying periods. Thereafter it was left to the relatives or to the general practitioner to contact the day hospital if deterioration occurred. A medical social worker attached to the geriatric service dealt with problems of patients attending the day hospital. Records about day patients were initiated in the day hospital and subsequently were incorporated in the group medical records system. If necessary a folder about a patient could be obtained easily from the group medical records department.

Activities

Medical activities were limited to diagnostic procedures which could not be carried out on an out-patient basis. Detailed assessment with the remedial therapists was undertaken using equipment available in the day hospital. Use was also made of a consulting room in the in-patient accommodation.

Nursing activities included accompanying the patients to and from the hospital, escorting them to facilities elsewhere outwith the day hospital, assisting with the examination and treatment of patients, bathing, enemata, obtaining urine and stool samples, dressings, weighing, and care of indwelling catheters. Supervision of the administration of medicines prescribed by general practitioners was also undertaken. The staff nurse in charge also arranged visits to the hospital dentist, the ophthalmologist and the radiodiagnostic rooms of the hospital.

Occupational therapy covered recreation, diversional activities, light craft work and aids to daily living. The ADL activities covered a relatively wide range of activities in the very limited accommodation.

Physiotherapy was undertaken in a very simply equipped department in the in-patient area of the building two floors above the day hospital. Chiropody and dental services were obtained as required in the in-patient area. Instruction of relatives was undertaken in the in-patient area. Catering was provided from the kitchen of the main hospital and beverages and a limited number of main meals were provided from the kitchen area of the ADL section.

Pattern of activity

At 09.30 patients began to arrive at the geriatric block. Some entered the main entrance of the building, proceeding direct to the physiotherapy department. Others entered by a side door into the day hospital. At neither entrance was there any special provision to shelter patients while being assisted to and from transport. Those patients in the day hospital commenced occupational or diversional and recreational therapy. Those requiring baths or nursing treatment were dealt with by the nursing staff, bathing and some procedures taking place in the in-patient area of the building. After having a hot drink the majority of patients in the day area were moved to the physiotherapy department. Those who had started in the physiotherapy department were transferred to the day hospital for occupational and diversional therapy and any necessary nursing treatment. At mid-day the patients had lunch in the main area of the occupational therapy department. After lunch there was a short period for group and social activities for all patients before they were taken home at 14.00. Because of difficulties in obtaining privacy in various situations the sexes were not mixed, men and women attending on different days as far as was possible.

Such as it was, the day hospital accommodation was used intensively throughout the working period but difficulties for the staff were caused by the lack of staff accommodation and nurse working rooms. Because of the separation of the various facilities, comment by the study team is limited to stating that a valuable service was being delivered to the patients by staff working in very difficult conditions. The movement of patients and their activities were highly integrated and organised.

DAY HOSPITAL 5

A disused laundry and boiler house was converted and extended in 1971 by adding a commercial timber system building: the existing building is of traditional stone and timber construction. Site configuration required the provision of ramps at the entrance, the fire exit and within the day hospital. An assessment unit was located in a separate building on the same site.

Relevant data

The day hospital provided 25 places but the number treated depended on availability of physiotherapy staff; at the time of the survey 40 to 50 patients were receiving treatment a week giving a ratio of two patients to one place. The semi-urban population of 62,000 served gave ratios of approximately one day place to 2,800 of the population and one day patient to 1,400 of the population.

Design comment

1 There was inadequate protection at the entrance for patients alighting from transport

2 The vestibule inner doors had been removed to accommodate folding wheelchairs; this resulted in direct entry into the physiotherapy exercise area, with consequent draughts and discomfort

3 Circulation through both physiotherapy areas caused confusion which was aggravated by the general lack of space

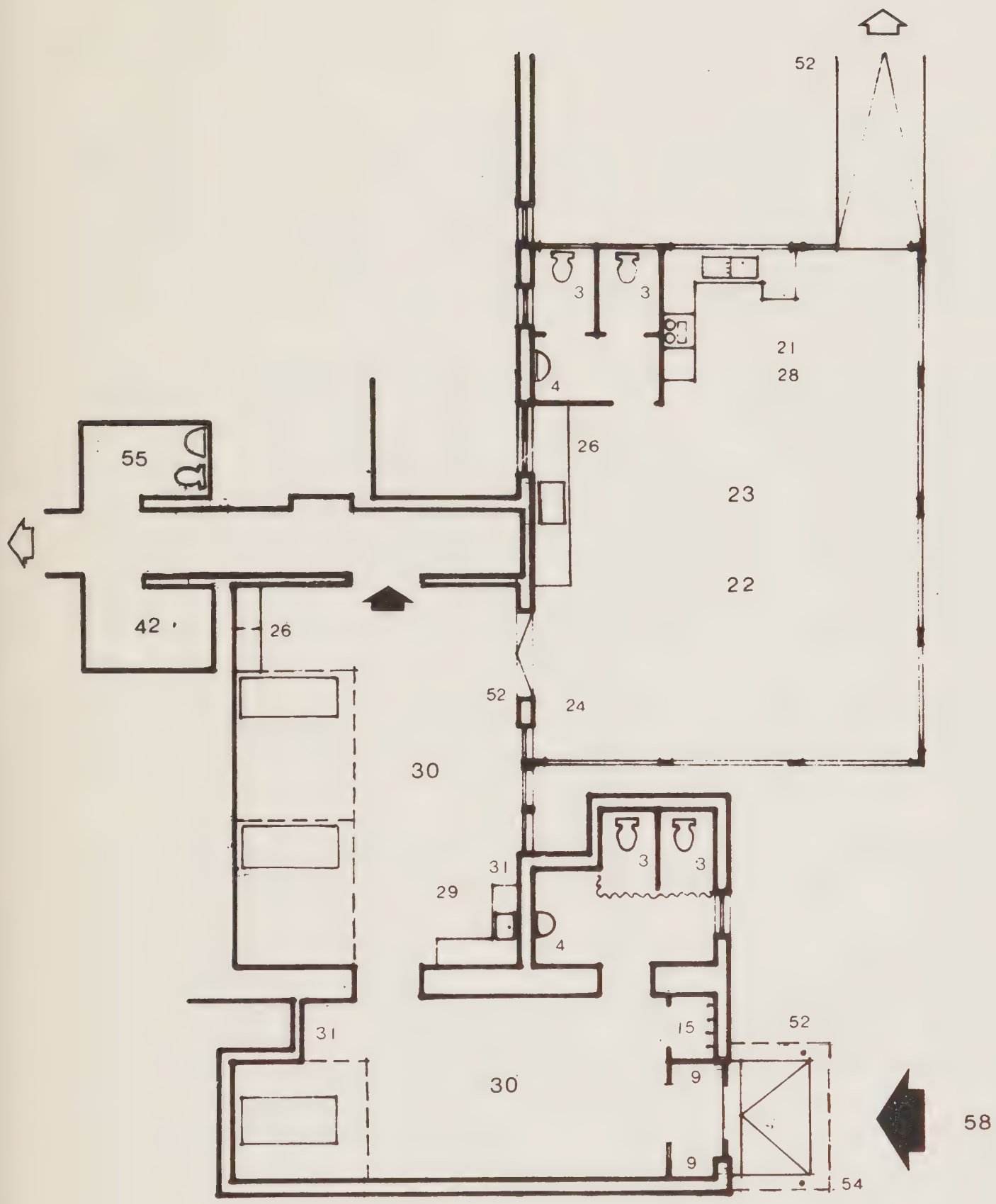
4 The area of 61.3m² (660 sq ft) allotted to daily activities in relation to numbers of patients served was inadequate for its multi-function use - dining, occupational therapy and aids to daily living. Unprotected radiators, particularly in this area, were a potential hazard

5 WC compartments lacked privacy and their size made them difficult to use by both assisted and wheelchair patients; they were 1.1m (3'8") x 1.5m (5'0")

6 Exposed unlagged main hospital heating supply pipes combined with small areas of openable window, created uncomfortable working temperatures.

General

The criteria for admission were depression, loneliness, physical disability following paralysis, and general debility. Before admission patients were seen in the consultative out-patient department. The homes of all patients were visited by the geriatricians. No incontinent patient was admitted. A small proportion were admitted direct to the day hospital following domiciliary visits. No local authority health visitors had a formal attachment to this hospital.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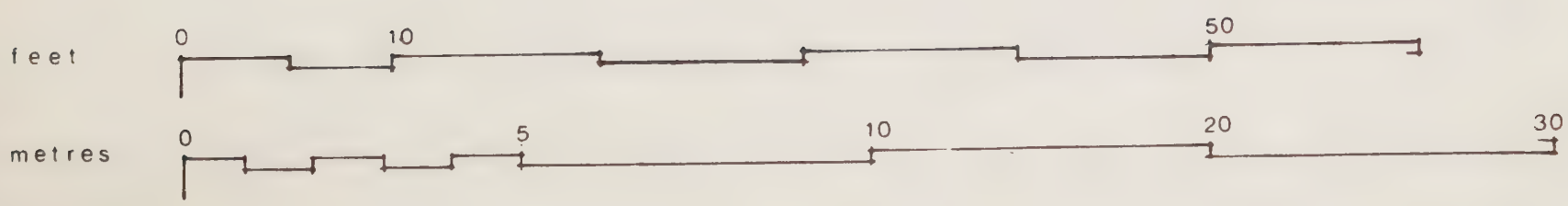
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Weekly review clinics, to which a health visitor occasionally came, were held. The condition of each patient was systematically reviewed at monthly intervals. A medical social worker, working full-time for the area geriatric service spent a limited amount of time with the day hospital. The group medical records system was used, the records of patients currently under treatment being held in the day hospital.

Activities

Limited diagnostic and therapeutic medical activities were undertaken in the consultative suite but physical assessment was undertaken in the ADL section. No examination facilities were available in the day hospital although on occasions a physiotherapy cubicle was used in cases of urgency. A general practitioner employed on a part-time basis in the geriatric service visited the day hospital each day.

The lack of nurse working rooms or place of reference for the nurse meant that nursing activities were confined to attending to a patient's immediate needs, such as toileting, changing soiled clothing, preparing patients for lunch and assisting with feeding when required. Simple dressings to small skin lesions were applied in a physiotherapy cubicle, more complicated dressings or other nursing procedures including bathing being performed in a ward outwith the day hospital. Soiled clothing was washed in a wash-hand basin in the WC and dried on a rail there. Patients brought medicines prescribed by their general practitioners and nursing staff supervised their administration.

Occupational therapy was limited to recreational and light craft work. If a patient was fit to climb stairs some ADL activity of limited value could be carried out in a room on the first floor.

Physiotherapy was confined to simple individual treatments and therapy in two cubicles and walking exercise in part of the circulation space.

Chiropody was undertaken on one session a week in one of the physiotherapy cubicles. Patients requiring dental treatment were referred to a local general dental surgeon. Hairdressing, bathing and instruction of relatives was performed in a ward. Catering was provided from the main kitchen of the hospital but hot drinks were prepared on a domestic stove in the day room. Speech therapy, provided by the local authority on a "repayment" basis, was undertaken in accommodation in the outpatient department for one 3-hour session per week.

Pattern of activity

About 09.30 patients arrived in ambulances. Their outer clothing was removed and, unlabelled, hung on hooks in the area used by the physiotherapists for walking exercises. The patients then moved through the main physiotherapy area to the day room where they were given a hot drink.

About 10.00 recreational and light diversional activities commenced in the day room, some of the patients being engaged in basket work. Other patients proceeded to physiotherapy. About 11.45 activities in the day room ceased as the tables had to be cleared and prepared for lunch which was served just after mid-day. This was completed about 12.45 after

which patients had a rest period or engaged in social activities. The diversional activities recommenced about 14.00 and further treatment in the physiotherapy cubicles and walking exercise area continued. Just after 15.00 the patients were given a hot drink and prepared for their journey home. The activities of the day hospital were completed by 16.00.

Comments by the study team are confined to the following points:-

1 The accommodation available, even with the additional wooden extension, resulted in very cramped conditions for staff and patients

2 The lack of basic nurse working accommodation for nursing staff grossly limited the nursing activities which could be undertaken

3 Similar considerations applied to the remedial therapists

4 Medical activities were also limited by the lack of space

5 WC facilities for patients left much to be desired

6 In spite of the difficult working conditions for the staff the patients undoubtedly received considerable benefit from attendance at this day hospital.

DAY HOSPITAL 6

A simple conversion (1968) of part of the in-patient accommodation in a former poorhouse utilising stud partition to form some staff working rooms and additional sanitary provision. A large long-stay unit was on the same site.

Relevant data

The day hospital's 40 places were providing facilities for 79 patients giving a ratio of two patients per place. With a population of 150,000 served in an urban area this gave ratios of one day place to 3,750 of the population and one day patient to 1,900 of the population. Patients of all age groups were accepted. Because of bad weather, only 21 patients attended on the day of the visit.

Design comment

1 The linear plan some 61.0m (200') based on a 1.4m (4'6") wide spine corridor resulted in both strained and restricted circulation

2 The WC compartments measuring 1.8m x 1.8m (6'x 6'), opening off the entrance area were the most suitable in terms of size and were used most frequently, irrespective of travelling distance. However the position of the WC in the compartment and the layout of fitments lead to difficulties with assisted and chairfast patients

3 The patients' cloakroom, located near the main entrance, could not be supervised

4 The day activity spaces at 117.4m^2 (1265 sq ft), or 2.9m^2 (31.6 sq ft) per person, would be required when the 40 patients attended

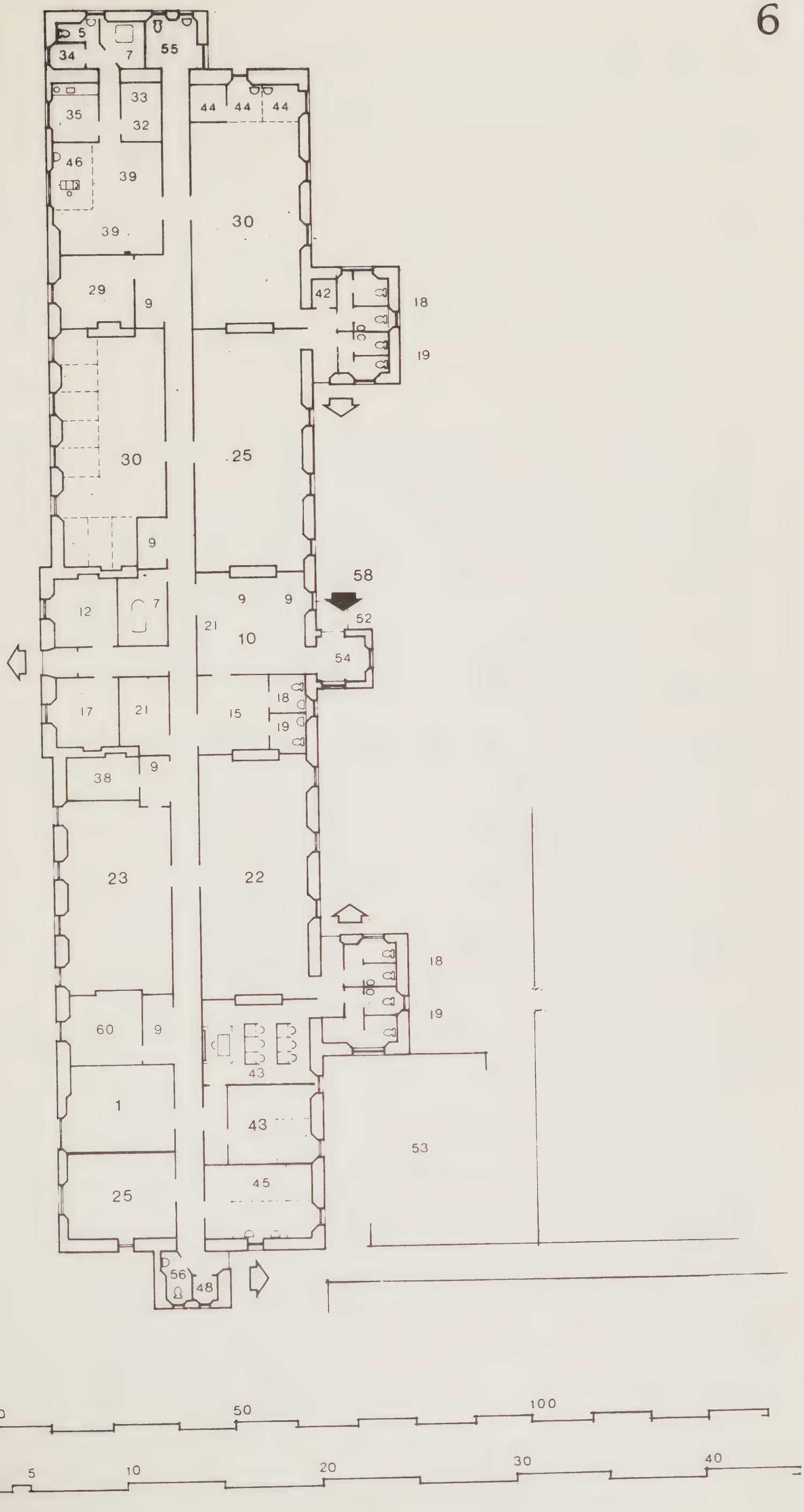
5 Walking aids were stored convenient to the entrance area and the physiotherapy department in a purpose-built bay 3.0m^2 (32 sq ft) in the main corridor

6 There were too few purpose-designed storage facilities in the occupational therapy room

7 A well-equipped speech therapy unit with language laboratory unit was provided.

General

The majority of patients were admitted for therapeutic purposes - mainly physical, but a limited number were undergoing drug therapy controlled by their general practitioner. A proportion were admitted for nursing purposes eg bathing, dressings etc. Up to 20% were accepted for social reasons. The majority of patients had been seen as in-patients or out-patients at hospitals elsewhere in the area but a proportion were referred direct to the day hospital. About 20 patients attended from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the adjacent in-patient unit on a pre-discharge basis or to use the remedial facilities available in the day hospital. Mild incontinence of urine was not a bar but if it did not improve after admission patients were transferred to an in-patient unit. Incontinence of bowel was a bar.

Home visits were the exception rather than the rule. Reports on home conditions were obtained from health visitors of the appropriate district. One medical social worker attached to the long-stay unit spent a proportion of her time in the day hospital but it was not possible to make an accurate estimate of the time spent in this activity. The records used were part of the group medical records system. Records of patients currently under treatment were held in the day hospital.

Activities

New patients were examined initially by a part-time medical assistant who attended the day hospital each morning. This consultation was followed up by joint consultation with the remedial therapists. Individual patients were reviewed at a weekly conference attended by the consultant, the part-time medical assistant, the senior nurse and the remedial therapists. Limited diagnostic and therapeutic medical activities were undertaken in the treatment room or in a rest room. Nursing activities consisted of toileting, bathing, dressing small wounds and ulcers, assisting with medical examinations, and obtaining and testing urine samples. A nursing auxiliary accompanied the patients in the ambulance.

Occupational therapy covered recreational, diversional activities, light craft work and woodwork. The ADL section which contained a kitchen with work tops was used for the intensive instruction of individual patients. This mainly involved the preparation of mid-day meals for a small number of patients.

Physiotherapy consisted of individual treatments in a well-equipped department and in a gymnasium. These activities were aimed at increasing the mobility of patients. The amount of work undertaken was limited by the availability of physiotherapists.

A chiropodist attended the day hospital for one session per week, seeing approximately one patient from the day hospital but others from the in-patient area. An area of the gymnasium had been partitioned off for this purpose.

A general dental surgeon attended for one session per week to deal with patients mainly from the in-patient area. Relatively few day patients required his services. A dental unit was provided in the treatment room. No doctors other than staff of the unit came into the day hospital. Local health visitors and district nurses contacted the day hospital, occasionally paying visits, but had no formal commitment to the unit. An optician attended monthly to deal with mainly in-patients, but occasional day patients were seen in the rest room. A well-equipped speech therapy department provided an area service for out-patients, in-patients and day patients; this suite was used for approximately 6 day patients on 4 mornings a week. A voluntary organisation had provided a special ambulance for the transport of day patients.

Instruction of relatives was limited and arranged by the sister as required. Hairdressing of female patients was undertaken in a salon. The sister was regarded as the co-ordinator of activities. The clinician in charge did not regard the unit as being wholly a geriatric day hospital; this resulted in a wide spectrum of age and clinical interests in the patients attending.

Pattern of activity

Patients began to arrive about 10.00. After passing through simple double doors and an entrance hall with adequate parking space for wheelchairs they entered a cloakroom where outer clothing was removed and hung on hat and coat hooks. Clothing was labelled but there was little security for valuables. Two WCs were provided in the cloakroom but access for wheelchair patients was difficult. The patients then received light refreshments before proceeding to the day room, the OT department or the physiotherapy department.

Remedial therapy commenced about 10.30 and proceeded until about mid-day when lunch was served. These activities recommenced about 14.00 until about 15.30 when the patients were assisted to prepare for their journey home. The pace of remedial activities remained much about the same throughout the day and was not intense.

Nursing activities including general supervision of recreational activities, continued throughout the whole day. The treatment area which was also used for medical examinations and dentistry in addition to the application of dressings etc was adjacent to a clean utility area and a linen store: these had been partitioned off. Also related to this area were two WCs and a bathroom with a "sitting" bath: these facilities were used very infrequently because access was difficult and because of distance and door width. A second bathroom had a free-standing bath and a mechanical hoist. There was adequate space for two nurses to work with a patient. The basic facilities required by nurses were isolated from the main patient areas.

An interesting feature was a patients' garden with raised flower beds of varying heights and two greenhouses. In the summer months this area was used to a great extent by the patients when weather permitted.

Comments by the study team are confined to the following points:-

1 The long narrow corridor presented difficulties for the movement of staff and patients, particularly if they were using walking aids or wheelchairs

2 Although 11 WCs were provided for patients many of these were difficult of access, particularly for patients in wheelchairs, as the doors opened inwards

3 Although adequate facilities were provided for remedial therapy the activities undertaken were limited because of staff shortages

4 Staff accommodation was limited to two offices and a staff WC

5 Although a dish washing machine had been provided in the small pantry it could not cope with the dirty dishes from the main meal, consequently washing of some of the dishes had to be undertaken by hand.

DAY HOSPITAL 7

Former Part III accommodation on two floors, converted in late 1969 into Board Offices on the upper floor and a day hospital at ground floor level. A small long-stay unit was on the same site with 10 beds allocated for assessment. An existing verandah had been retained for summer use: minimum structural changes had been carried out, restricted mainly to cutting and widening the formation of openings to facilitate the movement of wheelchairs. Bathroom and WC provision had been provided to both the day areas and the verandah.

Relevant data

The hospital's 10 places with 20 patients attending per week gave a ratio of two patients to one place. The population served was 9,000 in a rural area; this gave ratios of one day hospital place to 900 of the population and one day patient to 450 of the population.

Design comment

1 Ground configuration made construction of a sheltered area for alighting patients difficult. Ramp access was too steep for assisted wheelchair patients

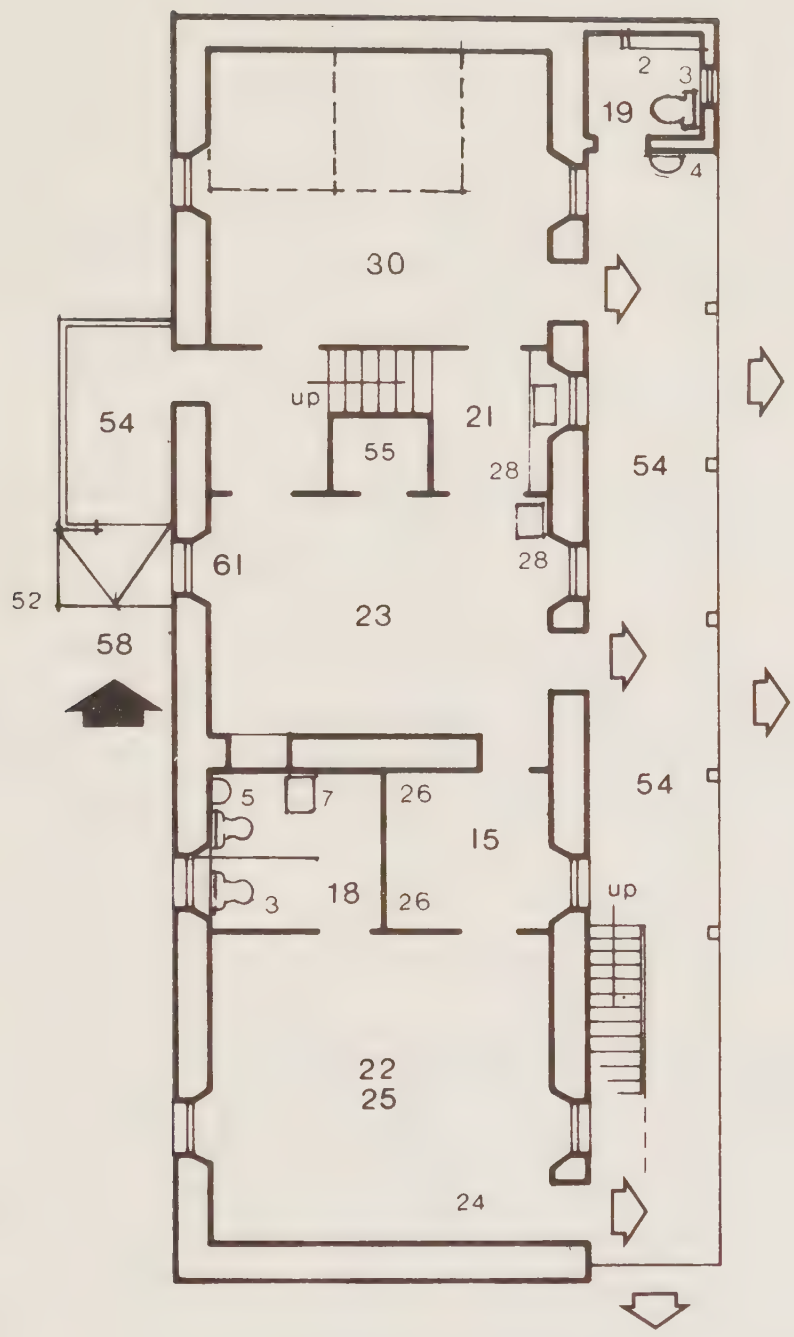
2 The small entrance hall made it difficult to manoeuvre wheelchairs

3 Simple decoration of the accommodation had achieved a domestic atmosphere

4 The WC in the bathroom adjoining the occupational therapy room was the only one in use because access to the other was via the verandah which was not used during the winter months.

General

Criteria for admission were the need for general support of patients who were frail, and suitability for the limited amount of physiotherapy and diversional activities which could be provided. Detailed assessment of patients was not undertaken. Patients were referred to the day hospital, placed on a waiting list and admitted as a place arose. No consultative geriatric clinics were held. The geriatrician discussed patients with the nurse and the diversional therapist when he paid visits, once or twice weekly, seeing individual patients as required. Additional help was obtained from a community social worker employed by the Board of Management and the Local Authority on a joint basis. Domiciliary visiting was rare. Review arrangements were on an ad hoc basis. Incontinence of bladder was not a bar in the first instance, although failure to improve required admission to an in-patient unit. It was difficult to pursue an active policy of discharge because of the high proportion of aged in the community and the lack of facilities. In spite of this, good relationships existed with the local authority. Medical social work was not undertaken. The only records maintained were those kept by the nurse and the diversional therapist.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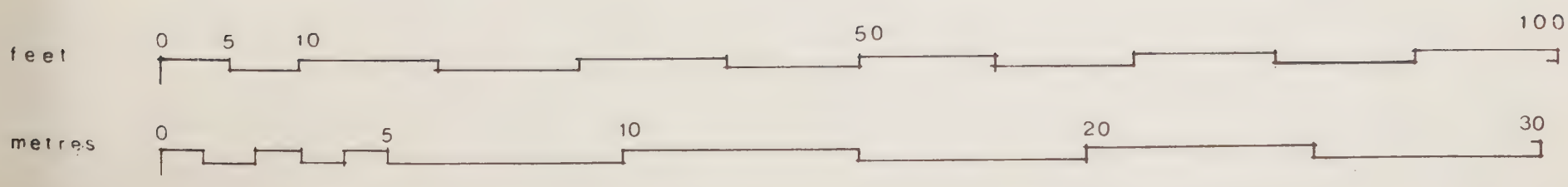
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Activities

Very little in the way of diagnostic or therapeutic medical activities were undertaken in this day hospital.

Activities generally were very much a combined effort between the nurse and the diversional therapist. They received patients on their arrival, assisted them in removal of outdoor clothing and settled them in the day room. Between them they planned the patients' day. The diversional therapist arranged, taught and supervised light handicrafts and the nurse frequently helped in this activity. During the morning the nurse, assisted by a colleague from the main hospital, was occupied in bathing and hair washing. All patients were bathed weekly, female patients had their hair washed at the same time. The nurse supervised the taking of medicines. Occasionally minor dressings to small skin lesions were performed. The nurse also undertook supervision of simple walking exercises and simple physiotherapy activities including heat treatment and checked the administration of drugs prescribed by general practitioners. The day hospital was visited on rare occasions by the physiotherapist from the long-stay unit.

The diversional therapist concentrated on diversional and social activities including the making of simple articles. Occasional group activities were undertaken.

A chiropodist attended for one session every 3 weeks to see 2 or 3 patients. Patients requiring dental inspection or treatment were referred to a local dental surgeon. Catering was provided from the main kitchen: hot drinks were prepared on a domestic cooker in the day hospital.

Pattern of activity

On arrival patients' outdoor garments were removed in the dining room and stored in an area adjacent to the OT department store on simple hooks, the garments being unlabelled. After coffee in the dining room patients moved into the OT room to undertake light craft work. The nurses undertook certain activities in this area and in the bathroom or WCs opening off it: facilities for these activities were very limited. Lunch was served in the dining room about mid-day. About 13.45 recreational and light diversional activities recommenced in the day room. Later in the afternoon the nurse took a limited number of patients through to the physiotherapy room which was moderately well equipped with simple equipment. There she supervised exercises. Afternoon tea was served about 15.00 after which patients were prepared for their return journey home.

Comments by the study team on this day hospital will be confined to the following points:-

1 Good use was being made of limited facilities

2 The sparsely populated area served by this particular day hospital made the staffing by trained physiotherapists and occupational therapists particularly difficult

3 A physical link with the long-stay in-patient unit would probably have enabled more effective use of resources but because of site conditions it would be difficult to achieve in this particular location

4 Because of the limited range of diagnostic and therapeutic procedures which could be undertaken this particular day hospital tended to be more of a day centre

5 The development of day hospitals in a rural setting, particularly in an isolated situation, produces special difficulties.

DAY HOSPITAL 8

Conversion (1971) of a former 16-bed infectious diseases ward in a small rural hospital. The main assessment unit was 25 miles distant. Other than the formation of new door openings, no structural alteration had been made. Existing WC accommodation had been upgraded. A new bathroom with shower, a separate WC and a kitchen opening off the new dining room, had been provided. Circulation was achieved principally by passing through adjoining compartments.

Relevant data

The 12 places with 23 patients attending per week gave a ratio of two patients to one place. In a population of 9,000 in a rural area this gave ratios of one day place to 750 and one day patient to 390.

Design comment

1 The unprotected access ramps although 'non-skid' were at a slope (1:5) difficult for pedestrian let alone wheelchair access

2 The narrow width 1.2m (4'0") of entrance hall/cloaks created a circulation problem

3 Sister's room was badly sited in relation to the day areas. The multi-purpose use of Sister's room for office work, storage and preparation activities was unsatisfactory

4 Storage provision for equipment including wheelchairs, walking aids and material was inadequate

5 The attempt to achieve privacy between day room and adjoining WC compartment by means of using two doors in a wall thickness of 500mm (21") was interesting.

General

Criteria for admission were general social support, suitability for the limited physical therapeutic facilities available, limited nursing activities and to some extent social factors. General practitioners who considered a patient suitable completed a form which was referred to the nursing officer in charge of the hospital. The nursing officer then visited the patient and his relatives, assessed the home circumstances and subsequently arranged admission to the day hospital when a place was available. So far as could be ascertained there were no direct referrals to the day hospital from the geriatric assessment unit. A consultant geriatrician visited the hospital weekly, saw a limited number of patients and subsequently discussed them with the local general practitioners. A combined general medical/geriatric out-patient clinic was held at monthly intervals in accommodation adjacent to the day hospital. Geriatric patients attending the day hospital were referred to this clinic as required. There was no clear cut discharge policy -

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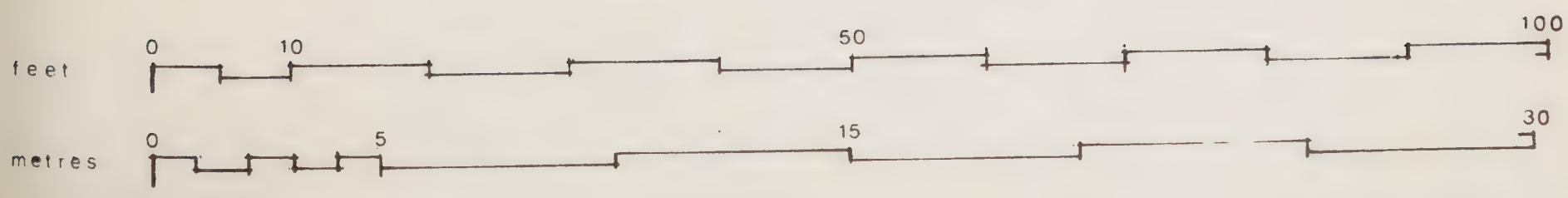
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it depended on the condition of the individual patient. The follow-up and review arrangements were made on an ad hoc basis. Patients who were incontinent of bowel or bladder were admitted to the day hospital.

The nursing officer had close contacts with the community nurses and social workers. Records of individual patients currently attending the day hospital were available from the group medical records department.

Activities

Diagnostic and therapeutic medical activities were very limited. Nursing activities were concerned with the reception and settling of the patients on arrival, bathing and hair washing about four patients a day, changing approximately one dressing per day, administering medicines, giving injections and eye bathing. The nurses arranged and supervised recreational and diversional therapy for patients and were assisted by members of the WRVS in the afternoons.

"Occupational therapy" was confined to recreational and simple diversional activities undertaken by the nurses. Occasionally patients were given practice in getting in and out of a bath in the bathroom and getting on and off a couch in the "physiotherapy" area of the day hospital. Physiotherapy was limited to simple exercises and activities supervised by the nurses. Simple equipment was used and patients were helped to walk. Adjacent to the day hospital was a small physiotherapy department visited by a physiotherapist for three sessions per week. Patients from the day hospital could be referred when the physiotherapist was attending but the numbers involved were relatively few.

No speech therapy was undertaken. A chiropodist visited for one session per week seeing on average three patients in a cubicle in the main physiotherapy department. Patients requiring dental treatment were referred to a local dental surgeon. Hairdressing of female patients was performed when they were bathed, hair being dried in the dining room where there was a wall-mounted dryer. Instruction of relatives was undertaken by the nursing officer. Catering was provided from the main hospital kitchen but hot beverages were prepared in a small kitchen with a domestic cooker.

Pattern of activity

Patients began to arrive about 09.00, their outer clothes being removed and hung on clothing hooks, to which name bracelets were hung. Moving from this congested area patients entered the day room where they were settled with a hot drink and simple recreational activities commenced. After all the patients had arrived simple craft activities commenced and a limited number of patients were taken to the day hospital's "physiotherapy" area for simple exercises. Others were given the necessary nursing procedures, bathing etc. Nursing activities were mainly undertaken in the bathroom and toilet area; a mechanical lift was available. However, basic nurse working rooms were lacking. Resource had to be made to much improvisation for storage of clean equipment and disposal of used items. Drugs, prescribed by the patients' general practitioners, were administered by the nursing staff.

Patients received their lunch about mid-day in the dining room; this was unused throughout the remainder of the day apart from serving as a circulation route.

In the middle of the afternoon patients were given afternoon tea and gradually assisted to prepare for their return journey.

One office was used as a general purpose room by all staff, but mainly by the nurses and also for storage.

The main comments to be made about this unit by the study team were that considerable ingenuity had been exercised by the nursing staff in obtaining the maximum use of limited physical resources and accommodation. The absence of remedial therapists participating actively in the work of the unit was a distinct disadvantage. It was unfortunate that the physiotherapy department of the main hospital, although limited in its facilities, was not used to a greater extent.

PATIENT DATA ON DAY OF VISIT

		HOSPITALS																								
		1			2			3			4			5			6			7			8			
		T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	
1	No. of patients	40	12	28	26	5	21	13	6	7	11		11	14	2	12	21	11	10	7	1	6	12	9	3	1
2	Age (average)	74	70	76	72	70	72	69	67	73	75		75	68	84	65	58	57	58	66	64	66	75	77	71	2
3	Married	10	6	4	8	3	5	4		4	2		2	5		5	13	8	5	2		2	8	6	2	3
4	Single	7	1	6	8	1	7	4	1	3	5		5	4	1	3	3	2	1	2		2				4
5	Widowed	23	5	18	10	1	9	5	1	4	4		4	5	4	1	5	1	4	3	1	2	4	3	1	5
6	Lived alone	16	3	13	8		8	1		1	1		1	4		4	1		1	1		1	1	1		6
7	Lived with relative or other	24	9	15	18	5	13	12	6	6	10		10	10	1	9	20	11	9	6	1	5	11	8	3	7
8	Distance from unit 0 - 1 mile	2	1	1	9	1	8							1		1	4	1	3	5		5	6	5	1	8
9	1 - 5 miles	29	10	19	16	4	12	6	2	4	9		9	10	1	9	16	10	6				4	2	2	9
10	5 - 15 miles	9	1	8	1		1	7	4	3	2		2	3	1	2	1		1	2	1	1	2	2		10
11	over 15 miles																									11
12	Ambulant (self sufficient)	14	4	10	8	1	7	4	1	3	5		5	5	2	3	8	3	5	2		2	2	2		12
13	(with help)	20	7	13	17	3	14	8	5	3	5		5	8		8	11	6	5	4	1	3	10	7	3	13
14	Confined to wheelchair	6	1	5	1		1	1		1	1		1	1		1	2	2		1		1				14
15	Hemiplegic (right side)	9	5	4	5	1	4	2	2		2		2	4		4	9	4	5	1		1	2	2		15
16	(left side)	4	2	2	7	3	4	2	1	1	3		3	2		2	3	3		1		1	4	3	1	16
17	Paraplegic	2	1	1																1		1				17
18	Arthritic	17	2	15	14	4	10	1		1	1		1	7	2	5	3		3	2	1	1	5	3	2	18
19	Amputee																1		1							19
20	Blind							1	1								1	1								20
21	Partially sighted	5	2	3							1		1	3	1	2							3	3		21
22	Deaf	2	1	1										1	1		3		3							22
23	Hard of hearing	11	2	9	1		1	4	2	2	2		2	1		1	2	1	1				4	3	1	23
24	Diabetic				1		1				2		2				4	2	2							24
25	Incontinent of urine	5	1	4	1		1	1	1														1	1		25
26	faeces																									26
27	doubly																						2	2		27
28	Needs help with feeding	2		2	2	1	1																			28
29	Taking oral medicine	28	12	16	18	3	15	9	4	5	10		10				11	4	7				7	5	2	29
30	Having injections	3	1	2				1	1																	30
31	Confused	1		1	3		3	6	3	3	4		4										1	1		31
32	Requires enemata occasionally	6	4	2	1		1				2		2													32
33	Is bathed	19	6	13	10	1	9	7	5	2	7		7				15	7	8	3		3	12	9	3	33
34	Has physiotherapy	30	8	22	13	3	10	7	3	4	9		9	12	2	10	9	3	6				12	9	3	34
35	occupational therapy	35	11	24	23	4	19	9	4	5	11		11	14	2	12	11	5	6	7	1	6	12	9	3	35
36	chiropody	23	6	17							10		10				15	5	10	6	1	5	12	9	3	36
37	speech therapy				5	2	3							2		2	6	4	2							37
38	Neurological lesion	1	1		1		1										2		2							38
39	Slight confusion	4	1	3																						39
40	Depression	6	2	4																						40
41	Parkinsonism	6	1	5	3		3	2	1	1	1		1													41
42	Atherosclerosis				2		2																			42
43	Social				2		2	3		3	4		4	4	1	3	7	5	2	4		4	3	3		43

Category of staff	HOSPITAL 1		2		3		4		5		6		7		8	
	40 places 160 patients per week		40 places 100 patients per week		15 places 27 patients per week		15 places 32 patients per week		25 places 50 patients per week		40 places 79 patients per week		10 places 20 patients per week		12 places 23 patients per week	
1 MEDICAL	staff from main unit readily available		staff from main unit readily available		staff from main unit readily available		staff from main unit readily available		Consultant - 1 day per week; GP daily visit		Consultant - 1 day per week; GP daily visit		Consultant - 1 day per week; GP on request		Consultant - 1 day per week; GP daily visit	
2 NURSING	Staff	Hours	Staff	Hours	Staff	Hours	Staff	Hours	Staff	Hours	Staff	Hours	Staff	Hours	Staff	Hours
Sister	1	34	1	40	1	20			1	10	1	32.5				
Staff Nurse	1	34	2	36	1	8	1	30							1	40
Senior Enrolled nurse	1	24														
Enrolled nurse			1	40	2	72					1	32.5				
Pupil Nurse			1	40												
Nursing Auxiliary	2	64	5	114	1	40	2	58	1	40	2	65	1	30	1	40
Whole-time equivalent	3.90		6.75†		3.50		2.20		1.25		3.25		0.75		2.00	
3 MEDICAL AUXILIARIES																
Chiropodist		6		2			From main hospital		3*		3*		ad hoc		ad hoc	
Dietitian				5	From main hospital		From main hospital								ad hoc	
Occupational Therapist		60		30		10		40				30				
Physiotherapist		89		60		10		6		60		30		ad hoc		ad hoc
Diversional Therapist		59								30		30		30		
Speech Therapist				12			Special sessions			3		12				
4 OTHER																
Dental Surgeon	1	24*	1*		From main hospital		From main hospital		ad hoc			3*		ad hoc		ad hoc
Physiotherapy Aide												36				

† Includes OPD work
* For whole hospital

APPENDIX V

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APPENDIX VI

1 Rest room
2 Urinal
3 W.C.
4 Wash basin
5 W.C./wash basin compartment
6 Shower
7 Bath
8 Bathroom
9 Wheelchair storage
10 Main waiting area
11 Shop/tea bar
12 Secretarial staff
13 Porter
14 Reception & records
15 Patients' out-door clothing
16 Duty room
17 Sister's room
18 Patients' W.C. – female
19 Patients' W.C. – male
20 Coffee area
21 Kitchen/Servery
22 Day area
23 Dining area
24 Occupational therapy office/base
25 Occupational therapy area
26 Occupational therapy store
27 Occupational therapy: finished article store
28 Aids to daily living
29 Physiotherapy office/base
30 Physiotherapy area
31 Paraffin wax bath
32 Preparation
33 Linen
34 Disposal
35 Sluice
36 Domestic washing machine
37 Furniture store
38 Staff room
39 Treatment
40 Clinette
41 Enema room
42 D.S.R.
43 Speech therapy
44 Chiropodist
45 Hairdressing
46 Dental suite
47 Dental workroom
48 Plant room (electrical)
49 Storage
50 Main staircase
51 Fire escape stair
52 Access/exit ramp
53 Patio/garden area
54 Covered area
55 Staff Cloaks/W.C. – female
56 Staff Cloaks/W.C. – male
57 Lift
58 Ambulance delivery point
59 Visitors W.C.
60 Consulting/examination room
61 Nursing station
62 Laboratory
63 Radiology

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